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Functional Mapping Report: Ministry of Health

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Abbreviations and Acronyms

AD	Administrative district: SNA district or municipality (as distinct from MOH's ODs)
ADB	Asian Development Bank
Admin	Administration
ANC	Antenatal care
Ank	Anukret – sub-decree
AOP	Annual operational plan (of MOH)
ARI	Acute respiratory infection
CAR	Council for Administrative Reform
CBD	Community based distributors (of family planning commodities)
CBHI	Community based health insurance
CBO	Community based organization (a legal entity registered with MOI)
CCT	Conditional Cash Transfer
CDC	Communicable disease control OR Cambodian Development Council
C-IMCI	Community Integrated Management of Childhood Illness
COM	Council of Ministers
CPA 1/2/3	Complementary package of activities (package of hospital and specialist services provided at referral hospitals organized at three levels of specialization)
CENAT	National Center for Tuberculosis and Leprosy
CNM	National Center for Malaria
C/S	Commune/Sangkat
CSF	Commune Sangkat Fund
D&D	Deconcentration and Decentralization
D/M's	Districts/Municipalities of the sub-national administration
DDC	District Development Committee
Dep	Department
DFDC	Department for Food, Drugs and Cosmetics (of MOH)
DG	Director General
DIC	Department for International Cooperation (of MOH)
DOP	Department of Personnel (of MOH)
DP	Development Partner
DPHI	Department of Planning and Health Information (of MOH)
DPM	Department of Preventive Medicine
Dr	Doctor
EDAT	Early diagnosis and treatment
EDL	Essential drugs list
EPI	Extended program of immunisation
FBD	Facility-based delivery
Fin	Finance
FM	Financial Management
FP	Family planning

HC	Health Center
HCMC	Health Center Management Committee
HCP	Health Coverage Plan
HEF	Health Equity Fund
HIS	Health Information System – administrative health information system of MOH
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
Hosp	Hospital
HP	Health Post
HRD	Human Resource Department (of MOH)
HSP2	Second Health Strategic Plan (2008-2015)
HSS	Health system strengthening
HSSP2	Second Health system strengthening Program
IA	Internal Audit
IMCI	Integrated management of childhood illness
IP3	Three year Implementation Plan the first 3 years of the NP-SNDD
MA	Medical assistant
M&E	Monitoring and Evaluation
MAFF	Ministry of Agriculture, Forestry and Fisheries
MCH	Mother and child health
MEF	Ministry of Economy and Finance
MoEYS	Ministry of Education, Youth and Sport
MOH	Ministry of Health
MoI	Ministry of Interior
MOLVT	Ministry of Labor and Vocational Training
MOSAVY	Ministry of Social Affairs, Veterans and Youth
MPA	Minimum Package of Activities (package of essential primary care services)
MRD	Ministry of Rural Development
MOWA	Ministry of Women's Affairs
NCDC	Non-communicable disease control
NCDD	National Committee for Sub-National Democratic Development
NCDD-S	NCDD Secretariat
NCHADS	National Center for HIV/AIDS, Dermatology and STI
NCMCH	National Center for Mother and Child Health
NCHP	National Center for Health Promotion
NIP	National Immunization Program
NIPH	National Institute for Public Health
NNP	National Nutrition Program
NP-SNDD	National Program for Sub-national Democratic Development
NRH	National referral hospital
NSSF	National Social Security Fund (under Ministry of Labor)
NSSF-C	National Social Security Fund for Civil Servants (under MOSAVY)

OD	Operational District of the Ministry of Health
ORS	Oral rehydration salts
PAE	Public administrative enterprises – also referred to as Public Institutions with Administrative Characteristics
PBB	Program based budget
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Program
PHD	Provincial Health Department
PM	Primary midwife
PMAS	Performance Management and Accountability System
PMI	Private Medical Insurance
PN	Primary nurse
PNC	Postnatal care
POC	Priority Operating Cost salary top-ups paid by DPs until 2012
PRH	Provincial Referral Hospital
RGC	Royal Government of Cambodia
RH	Referral Hospital OR Reproductive Health
RTC	Regional Training Center
SD	Sub-decree
SDG	Service development grant (a performance based grant to SOAs)
SM	Secondary midwife
SN	Secondary nurse
SNA	Sub-National Administration (with Councils and Boards of Governors)
SNFL	Sub-National Finance Law
SOA	Special operating agency
STI	Sexually transmitted infection
SUBO	MOH's subsidy scheme for poor patients exempt from user fees
TB	Tuberculosis
TOT	Training of trainers
TWG	Technical Working Group
ToR	Terms of Reference
UF	User fees
UHS	University of Health Sciences
UNICEF	United Nations Children's Fund
VHSG	Village Health Support Group
VHW	Village health workers
Vit	Vitamin
WB	World Bank
WCC	Women and Child Committee (of SNAs at each level of administration)
WG	Working Group
WHO	World Health Organization

Executive Summary of Key Issues Identified in MOH Functional Mapping

- **Local community participation functions in health are mostly unfunded mandates.** The functions listed in the MOH's community participation policy need to be costed, prioritized and Commune/Sangkat mandates and sources of funding clarified before they are transferred to sub-national administrations (SNAs).
- **Primary health care facilities are not present in all communes; health centres rely on support for their functions from MOH's Operational District (OD) offices.** It would be difficult to transfer primary health care functions and health centres to communes; transfer to district/municipality level would be more practical. It will also be necessary to ensure continuity of support to health centres from Operational Districts or higher levels of the health system.
- **The mismatch between MOH's 77 Operational Districts (OD) and 185+ SNA districts and municipalities means that there is no simple way to transfer MOH local functions to districts and municipalities.** Transferring all OD office functions and hospital service delivery to D/Ms would require substantial reorganization, new capital investment, additional staffing, retraining and re-deployment of existing staff and additional on-going budget. This is likely to be inefficient in most SNA districts. Other options that could be more efficient and less disruptive – such as joint transfer of shared functions to more than one D/M - should be considered in the MOH's Functional Review.
- **There is asymmetry in the assignment of functions to different MOH ODs.** Asymmetric transfer of health functions is likely to be necessary for municipalities where the province administration is located, because the provincial referral hospital functions as the district referral hospital for the municipality and neighbouring districts. Asymmetric transfer may also be needed in remote and sparsely populated provinces where the provincial health department may take on some district functions in order to achieve economies of scale.
- **Team-work and multi-tasking are pervasive in health centres and OD offices.** Integrated team activities should be kept together to the fullest extent possible in any functional transfers. Few or no staff in OD offices or health centres work on only one or two stand-alone functions that could be separated from other functions and transferred to SNAs.
- **Joint functions and linkages exist between different levels of the health system.** Many MOH functions joint functions of central, province, OD and health facility levels. This is a typical feature of public health systems around the world for reasons related to specialization and economies of scale, and the need for coordination of the referral and disease surveillance systems. D&D will require detailed regulations to be developed & new business processes to be developed to clarify the responsibilities of each level of administration in joint functions and maintain these linkages.
- **Some MOH functions are pilots, operating only in some parts of the country, and dependent on aid finance.** It may be desirable to evaluate these pilots, make a decision on whether to scale them up and adapt their design to D&D before functional transfers are made.
- **Special Operating Agencies are one such pilot.** Before SOAs could be decentralized, it would be necessary to develop a new legal instrument for a local semi-autonomous agency that is accountable to SNAs for performance.
- **Proposed reforms in health finance have major implications for the design of fiscal aspects of D&D**. There will be a need to ensure coordination of health finance and D&D policy decision-making processes at key stages.
- **MOH plans to update its Health Coverage Plan by 2015 and expand the health network and personnel to keep pace with population growth by 2020.** Updates from these new plans will need to be obtained before future decisions on personnel or facilities transfers.

I. Introduction: the Basis for Functional Mapping

The Ministry of Health (MOH) is required to carry out functional mapping according to the 2008 Organic Law on Administrative Management of the Capital, Provinces, Municipalities, Districts and Khans (Royal Kram No. NS/RKM/0508/017 – referred to as "the Organic Law"). The 2012 Sub Decree No 68 ANK, BK on General Processes of the Transfer of Functions and Resources to Sub-National Administrations (SNAs) reaffirms the legal basis for undertaking functional mapping and provides more information on the process and time frame. The Sub-Decree confirms that health is a priority public service for decentralization and accordingly the MOH is a priority Ministry. The National Program for Sub-National Democratic Development (NP-SNDD) of the Royal Government of Cambodia (RGC) is a ten year (2010-19) program for decentralization, delegation and de-concentration (D&D) of public services. Initial implementation plans are set out in the first Three Year (2011-13) Implementation Plan (IP3) which requires functional mapping of priority Ministries to be undertaken during the IP 3 period. The Ministry of Health's Functional Mapping Report follows as much as possible the manual and guideline of the National Committee on Sub-National Democratic Development-Secretariat (NCDD-S) on Mapping Functions of Ministries of the Royal Government of Cambodia, approved by the NCDD in September 2012.

The MOH established a Working Group on Decentralization and Democratic Development (D&D WG) to lead the MOH's functional mapping and functional review in December 2010. The WG is chaired by Secretary of State HE Te Kuy Seang.

II. Mapping of Key Functions in Laws and Regulations

A conceptual map of the major groups of functions of the MOH at each level of its administrations is summarized in Figure 1. The key laws and regulations setting out the MOH's functions and other health functions are:

- The Constitution of the Kingdom of Cambodia, under which the State guarantees the health of the people and must consider disease prevention as well as treatment. Article 72 of the Constitution mandates that the State should provide health care free of charge to poor people in public hospitals, infirmaries and maternities, and should establish infirmaries and maternities in rural areas. In practice, infirmaries are now referred to as health centres (HCs) and the function of maternities is carried out by HCs and referral hospitals (RHs).
- A law, Kram NS/RKM/0196/06 (1996) on Establishment of the Ministry of Health which establishes the Ministry's public service delivery role without detailing MOH functions. More detail on the MOH's mission and functions are described in Anukret 67 (1997). Its mission is "to lead and manage the health sector of Cambodia". Its functions are to:
    - Define health policy
    - Develop planning and strategy for the health sector
    - Develop regulations/guidelines to maximize the quality of health services in the public and private sectors
    - Monitor, control and evaluation the administrative and technical work of the institutes subordinate to the MOH
    - Research how to develop health sector
    - Manage resources (human, material, financial, and information) at central, province, municipal, district, khan and commune/sangkat level
    - Organize preventive programs and nursing care to decrease the causes of disease
    - Coordinate other resources
    - Oversee production, trade and distribution of drugs, medical equipment and paramedical equipment in all public and private health facilities

    - Control food safety.
- Ank. 67 also defines the organization chart and terms of reference (TORs) of the central level of the MOH and lists the national institutes, hospitals and provincial health departments (PHDs) that are subordinate to the MOH. The organization chart and TORS or the MOH's 24 provincial health departments (PHDs) and 77 operational districts (ODs) are set out in administrative orders (Prakas).
- Uniquely, Calmette Hospital is established by a Royal Decree (Kret) which gives it special semi-autonomous, **de-concentrated** status as a **public administrative establishment** (PAE) under the technical guardianship of the MOH and financial guardianship of the Ministry of Economy and Finance (MEF). Other national referral hospitals (NRH) and some national institutes have also been given semi-autonomy as PAEs by sub-decree. Twenty two ODs and eight provincial referral hospitals (PRH) have been given more limited **de-concentrated** status as **special operating agencies** (SOAs) as time-limited pilots supported by development assistance.
- Most health service delivery functions in the public sector are described in policy documents, strategies and guidelines approved by the Minister of Health, rather than formal legal documents. These documents do not generally define the distinction between obligatory and permissive service delivery functions, though they often set priorities and targets.
- The RGC and MOH responsibilities related to regulation of the private sector – the private health sector, health professionals, food and drugs, and abortion are governed by Kram, which give detailed indication of obligatory functions of the Ministry for regulation of these aspects of the health sector.

Table 1: Conceptual Map of the Major Groups of Functions of the Ministry of Health

	Central Level	Province Level	District Level (OD)	Commune Level
"Back office functions": policy, regulation, management, monitoring	-Policy & strategy -Coordinate planning, budget & aid - Regulate private sector - Inspect & supervise public health system	-Supervise & support ODs & RHs -Coordinate OD & PHD planning -Delegated regulation functions	-Supervise & support primary care -Coordinate HC & OD planning -Coordinate with SNAs & PHD to enforce regulations	-Community participation in governance of HCs -Community feedback initiatives supported by DPs, NGOs
Health human resource development	-Pre-service training of health professionals - Train trainers for in-service training	In-service training of health professionals	In-service training of health professionals	Train community health workers
Health service delivery	-Hospital care for Phnom Penh - Specialized hospital care for whole country -Coordinate disease control -National health promotion campaigns	-Hospital care for local OD -More specialized hospital care for whole province -Coordinate disease control in province -Local health promotion	-Primary Care, including local prevention & promotion -Hospital care for OD population	Basic health services, community mobilization & health education

Health finance	-SUBO at NRH -NSSF -NSSF-C -HEF implementer is an international NGO	-SUBO at PRH, or -HEF at PRH operated by NGO	-SUBO at PRH, or -HEF at RH operated by NGO -CBHI operated by NGO or CBO	-ID Poor -Enrol families in HEFs & CBHI
Health research	NIPH & contracting of private research agencies	-	-	-

Table 2 lists the functions of the MOH as defined in Kram, Kret, Anukret and Prakas, and provides references to the relevant legal documents. It maps these functions to the level of administration within the MOH which is responsible for the function. (Table 2 and all other detailed tables in this report are also provided separately as excel spread-sheets for ease of reference.)

Table 2: Detailed list of MOH Functions as Contained in Laws, Kret, Anukret & Prakas (1)

(numbers refer to Table 5 master list)	Function	Legal Mandate: Legal reference	Current Responsible Agency or Level of Administration (agency with major authority & responsibility in bold typeface): National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
A. Policy, regulation, general management, governance								
1	**General management, leadership**	Kram 0196-06,1996;Ank 67 , 1997 on MOH mission & organization	**MOH Cab, DGs, Directors, chiefs**	PHD, PRH	OD, RH, HC			
2	**Administration and personnel management**							
	Sub-functions							
2.1	General administration	ank 67 of 1997 on MOH mission & organization	**MOH, Dep Admin; Dep Legislation**	PHD	OD			
2.2	Personnel recruitment, deployment, promotion	Kram1094-006 Civil Service Law 1994	**CAR, SSCS, MOH, Dep Pers**	PHD	SOA ODs (c)			
2.3	Civil service administration, pay, discipline, ethics	Kram1094-006 Civil Service Law 1994	**COM; MOH Dep Pers, Dep Legis**	PHD	OD			
2.3	Incentives financed from user fees, insurance, SOA-SDGs	Ank 69, 2009, Creation of SOAs in Health; Prakas 348,1997, Pilot Health User Fees; Prakas 809,2006, Intermin. Dir. on support for poor patients	MOH Dep Personnel, DPHI; **NHs**	**PRH**	**OD; RHs;** HCs			
3	**Budget and finance**							
	Sub-functions							
3.1	Government budget and procurement (excl. drugs & vaccines logistics)	Kram 0508-016, 2008: Public Finance System; annual budget law □	**MEF**; MOH Dep Budget & Fin	**Governor, PEFD, Prov Tsy**, PHD	OD			
3.2	User fees & insurance revenue	Prakas 348, 1997, pilot user fees; Prakas 809, 2006, Intermin Dir on support for poor patients; no law for HEFs	MOH DPHI; **NHs**	**PRH**	**RH, HCs**		HCMC	
4	**Internal Audit**	Ank 40, 2005, Internal Audit in Ministries, Provinces; Ank 18,2006, Prakas 350, 2006, Creation & Function of Internal Audit in MOH	**MOH, Dep Int Audit**					
5	**Inspection & control**	Ank 67, Prakas 128, 2000,Role & Functions of Inspection & Control	**MOH DG for Inspection**					
6	**Planning & health information**							
	Sub-functions							
6.1	Planning monitoring & review	Ank 67	**MOH, DPHI**	**PHD**	ODs, HCs			
6.2	Health information systems, data collection , monitoring & analysis	Prakas_Function of PHD, 26 August 1998, MoH	**MOH, DPHI**	PHD	ODs; HCs			VHSG
6.3	Planning health facility network	Circular 85, 1995, Development & Implementation of HCP for Districts & Communes; Prakas approve new health facilities	**MOH DPHI, Minister approves new facilities**	**PHD proposes plan or facility; Governor approves**	OD provides input to province			
7	**Hospitals and other medical care regulation and standard-setting (includes MPA & HCs)**							
	Sub-functions							
7.1	licensing & inspection of private health facilities	Kram 1100, 2000:Licensing & Inspection of private health facilities; Prakas 041, 2002:Delegation to PHD of licensing; Prakas 034, 2011:Technical requirements for opening or closing private health facilities	**MOH, Dep Hospitals**	**PHD** + inter agency committee	OD	Inter agency committee		
8	**Health infrastructure construction & management**							
	Sub-functions							
8.1	Provision of new health infrastructure (buildings, fixtures, water & sanitation)	Kram 0112-004, 2012 & Ank 105, 2006: Public Procurement	**COM,** MOH Dep of Budget & Fin	Governor approves, PHD requests	OD provides input to province	Some D/M	Some CC	NGOs, donors, WB Proct Agent
8.2	Provision of non-medical equipment (furniture, vehicles …)	Ank 67, Ank 105	**MOH Dep of Budget & Fin; HSSP2 Secterariat**	**Governor, PEFD, PHD**		Some D/M		NGOs, donors
8.3	Maintenance of health infrastructure & non-medical equipment (furniture, vehicles..)	Ank 67, Prakas 308	**NHs**	**PHD**	OD			
8.4	Medical equipment provision & maintenance	Ank 67, Ank 105	MOH, **NHs**	PHD, **PRH**	RH			NGOs
8.5	Medical waste management	Ank 67	MOH, **NH**	**PRH**	**RH, HCs**			
9	**Food & Drugs, vaccines and commodities**							
	Sub-functions							
9.1	Regulation of pharmaceuticals manufacture, import, distribution, retail pharmacy; & food and cosmetics	Kram 0696-02,1996:Drug Management; Prakas 0211, 2006: Role and Functions of Food and Drug Control Agency	**MOH Dep Drugs, Food & Cosmetics**	**PHD** + inter agency committee	OD	Inter agency committee		Pharmacist Professional Association
9.2	Regulation of marketing of products for infant & young child feeding	Ank 133, 2005 & Prakas 61, 2007: Marketing of products for IYCF	**MOH Dep Drugs, Food & Cosmetics, NMCHC, MOC, M of Inf, M of Ind**					
9.3	drugs and commodities supply chain management; vaccine cold chain (e)	Ank 67, Ank 81	**MOH, Central Medical Store**	PHD; PRH	OD; RH; HCs			
9.4	Drug quality control testing	Kram 0696-02, 1996: Drug Management; Prakas 0211, 2006:Role & Functions of Food & Drug Control Agency	**MOH, Nat Medicine Control Lab**					

Table 2: Detailed list of MOH Functions as Contained in Laws, Kret, Anukret & Prakas (2)

(numbers refer to Table	Function	Legal reference	National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
9.3	drugs and commodities supply chain management; vaccine cold chain (e)	Ank 67, Ank 81	**MOH, Central Medical Store**	PHD; PRH	OD; RH; HCs			
9.4	Drug quality control testing	Kram 0696-02, 1996: Drug Management; Prakas 0211, 2006:Role & Functions of Food & Drug Control Agency	**MOH, Nat Medicine Control Lab**					
10	**Traditional medicine**	Ank 67	**MOH, NITM**					
11	**Supervising public health sector**	Ank 67, Prakas 308	**MOH** - most programs & departments	**PHD** (PRH & OD)	**OD** (HCs)			
13	**International health cooperation & aid coordination; int coop for control of emerging diseases**	Ank 67, Prakas 519, 2006: organization & function of dep internat. Coop of MOH	**MOH Dep Int Coop, DPHI, HSSP2 Secretariat; Dep CDC**	PHD	OD			
B. Health Human Resources Development Functions								
15	**Planning, management and coordination of training for HRH**							
	Sub-functions							
15.1	System Planning, policy guidelines, legal framework, and coordination of pre-service education and in-service training; management of HRH information	Ank 67, Prakas 33 of 1998 on establishment of Dept of HRD	**MOH, Dep HRD;** MOH provides input to MOEYS for degree programs					
15.2	Setting minimum standards for management and establishment of training institution for health (public and private)	Ank 21	MOH & **MOEYS** joint mandate					
15.4	Management and coordination of data base training	Ank 67, Prakas 33 of 1998 on establishment of Dept of HRD	**MOH, HRD**					
15.5	Registration and Licensing for HRH	Kret 0200-039, 2000 on Doctors' Association; 0905-396,2005 on Dentists' Association; 0906-389, 2006 on Midwives' Association, 0807-373 on Nurses' Association; 0210-162,2010 on Pharmacists' Association	**Med Prof Association, other professional associations**					
16	**Delivery of training to health workers**							
	Sub-functions							
16.1	Pre-service training delivery	Ank 67, Ank 127,2001 on UHS; Ank 129, 2002 on RTCs	**UHS, nursing school, RTCs**					private medical school
16.2	In service training delivery	Ank 67	**MOH, many departments deliver cascade training**	**PHD,PRH cascade training**	**OD, RH cascade training**			NGOs
16.3	Non-medical capacity development; including capacity development of community workers	Ank 308; Ank 51 gives mandate to MRD to train community health workers	MRD, Dep Rural Healthcare		**OD, HCs**			NGOs

Table 2: Detailed list of MOH Functions as Contained in Laws, Kret, Anukret & Prakas (3)

(numbers refer to Table 5 master list)	Function	Legal reference	National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
C. Health Service Delivery Functions								
17	**Primary care: basic health service delivery (MPA)**							
	Sub-functions							
17.1	Primary care service delivery	Constitution Art.72 (rural infirmaries)			**OD, HCs**			VHSG, NGOs
18	**Hospital and specialist care** in national specialist hospitals, CPA3 provincial referral hospitals, CPA 2 and CPA 1 district referral hospitals	Laws cover structures not service delivery function. Ank 67 lists NHs, Kret 1996 & 2009 on Calmette; Ank 96... 2009 estab Kh Soviet & other NHs as PAE; Ank 69 estab 8 PRH as SOA	**NH**	**PRH, CPA3**	**RH, CPA1 or CPA2**			**Kantha Bopha,** NGOs, private clinics
19	**Blood transfusion & blood bank services including regulation of blood donation & blood products**	Prakas 01, 1994: Blood transfusion & blood safety	**NCBT, NH**	**PRH**				
21	**Communicable disease control**							
	Sub-functions							
21.1	HIV/AIDS prevention	Kram 0702-012, 2002: Prevention of AIDS; Ank 67 (central structure not functions)	**NCHADS, NAA**	PHD	OD, RH, HCs			NGOs
21.2	HIV/AIDs testing, counselling, treatment and care	Kram 0702-015, 2002; Ank 67 (central structure not functions)	**NH**	**Clinic at PRH**	**Clinic at RH**			Private sector
21.3	TB prevention & awareness raising	Ank 70, 1995: Nat Com for TB; Ank 67 (central structure not functions)	**CENAT**	PHD	OD, HCs			NGOs
21.4	TB diagnosis & treatment (treatment at subnational level is included in MPA & CPA)	Ank 70, 1995: Nat Com for TB; Ank 67 (central structure not functions)	**CENAT, NH**	**PRH**	**RH, HCs**			**Village health workers**
21.5	Malaria, dengue & other parasitic disease prevention & vector control (treatment is included in MPA & CPA)	Ank 67 (central structure not functions)	**CNM**	PHD	**OD, HCs**			**Village Malaria Workers**
21.6	Avian influenza and other animal-human disease control (treatment is included in CPA)	Falls under CDC in general in Ank 67 & Prakas 308	**MOH Dep CDC, MAFF**	**PHD, PAFD**				
21.7	Other communicable diseases (treatment is included in MPA, CPA)	Ank 67, Prakas 308	**MOH, Dep CDC**	**PHD**	OD, HCs			VHSG
22	**Non-communicable disease control (h)**							
	Sub-functions							
22.1	NCDs including diabetes management and road traffic injury prevention (treatment is included in MPA, CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	**MOH, Dep Prev Med**	PHD, PRH	OD			VHSG, peer educators, NGOs
22.2	Mental health (treatment is included in CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	**NH**	**PRH**				NGOs
23	**Maternal, reproductive and child health (h)**							
	Sub-functions							
23.1	abortion services regulation	Kram 1197-06,1997: Abortion Law	**MOH, NMCHC**					
23.2	Child health & nutrition including immunization, well child checks,management of malnutrition, integrated management of childhood illness and CDD-ARI	Ank 67, Prakas 308 (central/PHD structures not functions)	**NCMCH, NIP, NNP**	**PHD, PRH**	**OD, RH. HCs**			VHSG, NGOs, **Kanta Bopha**
23.3	Reproductive, maternal & neonatal health and nutrition, including PMTCT, family planning, nutrition, ANC, PNC, facilities based delivery, newborn health checks	Constitution Article 72 (rural maternities), Ank 67, Prakas 308 (central/PHD structures not functions)	**NCMCH**	**PRH**	**OD,RH, HCs**			VHSG, CBD, NGOs, private pharmacies
24	**Disease prevention (primary prevention), health promotion and public health education in non medical settings (Also integrated into** functions 17 and 21-23)	Constitution Art 72; Ank 67; Prakas 308	**MOH NCHP & CDC Center & NMCHC**	**PHD**	**OD, HCs**			VHSG

Table 2: Detailed list of MOH Functions as Contained in Laws, Kret, Anukret & Prakas (4)

(numbers refer to Table 5 master list)	Function	Legal reference	National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
D. Health Finance Functions								
25	**Subsidized health insurance for the poor**							
25.2	SUBO	Prakas 809 of 2006: Interministerial directive on support for poor patients	**MOH Dep Budget & Fin, NH**	PRH	RH, few HCs			
E. Health Research Functions								
31	**Health research**	Ank 67, Prakas 308	MOH; MOH ethics comm; **NIPH**	PHD				NGOs; private sector

Table 3 lists MOH functions that are implemented in practice, even though there is no specific legal mandate. The main functions in this category are functions supported by development partners and NGOs, such as performance-based contracting of health facilities, such as service development grants for SOAs and health financing initiatives such as HEFs and CBHI. Additionally, some important functions and sub-functions of service delivery are not mandated in legal acts, but they are supported by policy documents and guidelines approved by the Minister of Health. Section III discusses these functions further.

Table 3 also lists functions that are legally mandated but not implemented in practice. Some MOH functions are not yet fully implemented in all parts of the country or at all levels because of constraints in human and financial resources. For example some functions involving regulation of the private health sector and private health education providers are not yet fully implemented. Some health functions are not yet fully implemented because there is a transition period before implementation of the applicable law. For example, the NSSF is going through a transition process to prepare for implementation of social health insurance for employees in the formal private sector.

TABLE 3: List of MOH functions practically implemented but not legally mandated and legal functions but not practically implemented (1)

(numbers refer to Table 5 master list)	Function	Legal Mandate: Legal reference	Legal Mandate: Practically implemented functions not legally mandated	Legal Mandate: Legal functions not practically implemented	Current Responsible Agency or Level of Administration (agency with major authority & responsibility in bold typeface): National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
A. Policy, regulation, general management, governance										
3	**Budget and finance**									
	SDG (SOAs only) and PBB (SOAs and PAEs only)		Implemented in 22 ODs, 8 PRHs with DP support		MOH **HSSP2 secretariat; NHs**	**SOA PRHs**	**SOA ODs**			
7	**Hospitals and other medical care regulation and standard-setting (includes MPA & HCs)**									
	Sub-functions									
7.1	licensing & inspection of private health facilities	Kram 1100, 2000:Licensing & Inspection of private health facilities; Prakas 041, 2002:Delegation to PHD of licensing; Prakas 034, 2011:Technical requirements for opening or closing private health facilities		Not yet possible to inspect all private facilities	**MOH, Dep Hospitals**	**PHD** + inter agency committee	OD	Inter agency committee		
7.2	Standard-setting and accreditation for public health facilities		Implemented in some sites		**MOH, Dep Hospitals**					
8	**Health infrastructure construction & management**									
8.4	Medical equipment provision & maintenance	Ank 67, Ank 105		Medical equipment committees planned, not yet implemented in OD RHs	MOH, **NHs**	PHD, **PRH**	RH			NGOs
12	**Community participation in governance**		Not MOH mandate but MOH implements in many sites					DDC (for RH)	**HCMC**	VHSG
B. Health Human Resources Development Functions										
15	**Planning, management and coordination of training for HRH**									
15.2	Setting minimum standards for management and establishment of training institution for health (public and private)	Ank 21		Enforcement of standards is not yet fully implemented	MOH & **MOEYS** joint mandate					
15.6	Management of accredication and certification of health professionals	***Missing reference***		Not yet fully implemented	**Accred Council of Cambodia**					
16	**Delivery of training to health workers**									
16.3	Non-medical capacity development; including capacity development of community workers	Ank 308; Ank 51 gives mandate to MRD to train community health workers	Not MOH mandate but MOH implements in many sites		MRD, Dep Rural Healthcare		**OD, HCs**			NGOs
C. Health Service Delivery Functions										
17	**Primary care: basic health service delivery (MPA)**									
17.1	Primary care service delivery	Constitution Art.72 (rural infirmaries)	Urban HCs/MPA services not formally mandated by MOH implements				**OD, HCs (h)**			VHSG, NGOs
17.2	Community mobilization and participation in primary health services	Ank 51 gives MRD mandate to mobilize rural community participation in health	Not MOH mandate but MOH implements in many sites						HCMC	**VHSG, NGOs**
18	**Hospital and specialist care** in national specialist hospitals, CPA3 provincial referral hospitals, CPA 2 and CPA 1 district referral hospitals	Laws cover structures not service delivery function. Ank 67 lists NHs; Kret 1996 & 2009 on Calmette as PAE; Ank 96,... 2009 estab Kh Soviet & other NHs as PAE; Ank 69 estab 8 PRH as SOA	RH network/CPA not formally mandated but MOH implements		**NH, Kantha Bopha**	**PRH, CPA3**	**RH, CPA1 or CPA2**			NGOs, private clinics
20	**Emergency transport to health facility**									
20.1	Ambulance & health facility to facility transport		Not formally mandated but MOH implements		**NH**	**PRH**	RH			Private sector
20.2	Village to health facility		Limited implementation				RH		some CCs?	VHSG, HEFs
22	**Non-communicable disease control (h)**									
22.1	NCDs including diabetes management and road traffic injury prevention (treatment is included in MPA, CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308		Limited implementation	**MOH, Dep Prev Med**	PHD, PRH	OD			VHSG, peer educators, NGOs
22.2	Mental health (treatment is included in CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308			**NH**	**PRH**				NGOs
23	**Maternal, reproductive and child health (h)**									
23.2	Child health & nutrition including immunization, well child checks,management of malnutrition, integrated management of childhood illness and CDD-ARI	Ank 67, Prakas 308 (central/PHD structures not functions)	Nutrition not an MOH mandate but MOH NNP implements some activities		**NCMCH, NIP, NNP**	**PHD, PRH**	**OD, RH. HCs**			VHSG, NGOs, **Kanta Bopha**
23.3	Reproductive, maternal & neonatal health and nutrition, including PMTCT, family planning, nutrition, ANC, PNC, facilities based delivery, new born health checks	Constitution Article 72 (rural maternities), Ank 67, Prakas 308 (central/PHD structures not functions)	Urban HCs/MPA services not formally mandated by MOH implements		**NCMCH**	**PRH**	**OD,RH, HCs**			VHSG, CBD, NGOs, private pharmacies

TABLE 3: List of MOH functions practically implemented but not legally mandated and legal functions but not practically implemented (2)

(numbers refer to Table	Function	Legal reference	Practically implemented functions not legally mandated	Legal functions not practically implemented	National Ministry or Agency	Province	Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
D. Health Finance Functions										
25	**Subsidized health insurance for the poor**									
25.1	HEFs		donor-supported pilots in most RHs and a third of HCs		**MOH DPHI (policy), HSSP2 secretariat (contracting), MOP (ID Poor)**		CBO (j)	CBO board	CBO board	**NGOs,DP**
25.2	SUBO	Prakas 809 of 2006: Interministerial directive on support for poor patients		NHs, some PRH and RHs where no HEF	**MOH Dep Budget & Fin, NH**	PRH	RH, few HCs			
26	**Social Health Insurance for Private formal Sector. Mandatory contributory social health insurance and management of the NSSF**	Kram 0902-012, 2002: establishing NSSF		SHI planned, not yet implemented; workers compensation implemented in 7 provinces	MOH, DPHI on NSSF board; **MOL Mandate, NSSF**	NSSF office				
27	**Social Health Insurance for Civil Servants and management of the National Social Security Fund for Civil Servant (NSSF-C)**		Draft law exists; MOSAVY is planning SHI implementation for civil servants		**MOSAVY** developing mandate & establishing NSSF-C,MOH DOP on Board					
28	**Voluntary health insurance**									
28.1	CBHI		No law ; donor-supported pilots in few districts		**MOH, DPHI**		CBO (j)	CBO board	CBO board	NGOs
29	**Vouchers for health services**		DP-financed pilots in few districts		**NMCHC**					NGOs
30	**Conditional cash transfers (e)**		DP-financed pilots in few districts		**MOI** lead implementer; MOH input on supply side		CBO	CBO board	CBO board	NGOs
E. Health Research Functions										
31	**Health research**	Ank 67, Prakas 308		PHDs do not conduct research	MOH; MOH ethics comm; **NIPH**	PHD				NGOs; private sector

III. Additional Key Functions in Strategy & Policy Documents

As noted above, some important functions of the MOH and the responsibilities of each level are authorized by guidelines, policy and strategy documents approved by the Minister of Health. As indicated by Table 3, many of the functions which are practically implemented but not legally mandated are new initiatives which have been supported by development partners (DPs), donors and NGOs. Increasingly, DPs have aligned their support with the strategies and policies of the MOH. Some initiatives are documented in project documents of specific DPs or donors. Some of these functions are pilots, carried out only in some parts of the country. Pilots are usually subject to evaluation after a defined period of time, and ideally, following evaluation a decision might be made on whether the pilot function should become mandatory (and then scaled up), obligatory (continuing in some areas of the country but not necessarily in all of the country) or whether the pilot should be terminated.

In some cases, MOH functions are conducted in line with draft policy guidelines, for example, the MOH's draft Community Participation Policy of 2008 which covers commune/sangkat health functions, updating and earlier approved community participation policy. There is no specific legal mandate for the MOH to carry out these functions, though the Ministry of Rural Development has a legal mandate for community health development. However, these functions are so important to the MOH's ability to achieve its mission, that the MOH and NGOs have mobilized resources and used health facility user fees to support them.

The functional mapping identified some important **new and developmental health functions that are likely to change over the next 5-10 years, during the implementation period of the D&D Organic Law.** The MOH is developing policies for some of these functions which may lead to future recommendations for the RGC to adopt laws or regulations and changes to organizational structures to scale-up some of these functions across the whole country. Key examples of these functions are:

- **quality accreditation** for hospitals and other health facilities, and
- **health financing schemes** to pay health care costs for the poor while permitting contribution by other citizens to the costs of health care. Health financing schemes also include voucher schemes for particular services (e.g. maternity services) and conditional cash transfers to poor families conditional on participation in priority public health programs such as childhood immunization, child health and nutrition check-ups and antenatal check-ups.

Health financing pilot schemes are authorized in general terms by the Health Financing Charter, a 1996 policy document and some aspects of the schemes are regulated by Prakas 348 (1997) and Prakas 806 (2006). Recent strategy and policy documents of the RGC indicate the government's commitment to scale up health equity funds (HEFs) to pay user fees for the poor, to implement health social protection for civil servants and scale up health insurance coverage for informal sector workers (e.g. in the form of Community Based Health Insurance Schemes (CBHI) or private medical insurance (PMI)). Social health protection for formal private sector employees is already authorized by Kram 0902-012 (2002) on the National Social Security Fund (NSSF) and is the responsibility of the Ministry of Labour and Vocational Training. The Ministry of Social Affairs, Veterans and Youth has established a PAE to develop and implement a National Social Security Fund for civil servants (NSSF-C) but at this stage, NSSF-C is developing policy and regulation. There is only a preliminary draft of a law to establish social health insurance for civil servants and others not covered by NSSF. The MOH is represented on the NSSF and NSSF-C Boards. The MOH is currently developing an updated health financing policy which may result in a revised Health Financing Charter and any recommendations needed for institutionalization of its strategies to achieve universal health coverage over the medium to longer term.

Table 4 lists functions defined by policies and strategies that are not legally mandated or differ from existing legal mandates.

Table 4: List of functions defined by medium term plans and strategies but not legally mandated or inconsistent with legal mandate

(numbers refer to Table 5 master list)	Function & Sub-Function	Legal Mandate: Legal reference	Legal Mandate: Med. term plans, strategies, policies define functions not legally mandated	Legal Mandate: Practically implemented functions not legally mandated	Current Responsible Agency or Level of Administration (agency with major authority & responsibility in bold typeface): National Ministry or Agency	Province	Other: Health Operational District	District/ Municipality/Khan	Commune/ Sangkat	Other
A. Policy, regulation, general management, governance										
3	**Budget and finance**									
3.3	Management of SDG (SOAs only) and PBB (SOAs and PAEs only)		SDG manual	Implemented in 22 ODs, 8 PRHs with DP support	MOH **HSSP2 secretariat; NHs**	**SOA PRHs**	**SOA ODs**			
7	**Hospitals and other medical care regulation and standard-setting (includes MPA & HCs)**									
7.2	Starndard setting and accreditation for public health facilities		HSP2, quality improvement program GD; SDG manual	Implemented in some sites with DP support	**MOH, Dep Hospitals**					
12	**Community participation in governance**		Draft community participation policy, 2008	Not MOH mandate but MOH implements in many sites				DDC (for RH)	**HCMC**	VHSG
B. Health Human Resources Development Functions										
16	**Delivery of training to health workers**									
16.3	Non-medical capacity development; including capacity development of community workers	Ank 308; Ank 51 gives mandate to MRD to train community health workers	Comm Participation Policy, 2008	Not MOH mandate by MOH implements in many sites	MRD, Dep Rural Healthcare		**OD, HCs**			NGOs
C. Health Service Delivery Functions										
17	**Primary care: basic health service delivery (MPA)**									
17.1	Primary care service delivery	Constitution Art.72, Prakas 120, 1996: Organization of the District Health Office	Guide for Strengthening the District Health System, 1997; MPA	HCs in urban areas not legally mandated			**OD, HCs**			VHSG, NGOs
17.2	Community mobilization and participation in primary health services	Ank 51 gives MRD mandate to mobilize rural community participation in health	Draft community participation policy, 2008	Not MOH mandate but health sector implements in many sites					HCMC	**VHSG, NGOs**
18	**Hospital and specialist care** in national specialist hospitals, CPA 3 provincial referral hospitals, CPA 2 and CPA 1 district referral hospitals	Ank 67, Kret 1296-94, 1996, 2006 Calmette estab as PAE; Ank 96, 2009 estab other NHs as PAEs; Ank 69, 2009 estab some PRH as SOA	Guide for Strengthening the District Health System, 1997; CPA GD, 2007	RH network and CPA services not legally mandated	**NH, Kantha Bopha**	**PRH, CPA3**	**RH, CPA1 or CPA2**			NGOs, private clinics
20	**Emergency transport to health facility**									
20.1	Ambulance & health facility to facility transport		CPA GD, 2007	No legal mandate but MOH implements	**NH**	**PRH**	RH			Private sector
20.2	Village to health facility		Comm Participation Policy, 2008	Limited implementation			RH		some CCs?	VHSG, HEFs
22	**Non-communicable disease control**									
22.1	NCDs including diabetes management and road traffic injury prevention (treatment is included in MPA, CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	CPA GD, 2007	NCD treatment not legally mandated	**MOH, Dep Prev Med**	PHD, PRH	OD			VHSG, peer educators, NGOs
22.2	Mental health (treatment is included in CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	CPA GD, 2007	NCD treatment not legally mandated	**NH**	**PRH**				NGOs
23	**Maternal, reproductive and child health**									
23.2	Child health & nutrition including immunization, well child checks,management of malnutrition, integrated management of childhood illness and CDD-ARI	Ank 67, Prakas 308 (central/PHD structures not functions)	MPA & CPA GD 2007; HSP2; many child health strategy, policy & GD	Nutrition not an MOH legal mandate.	**NCMCH, NIP, NNP**	**PHD, PRH**	**OD, RH. HCs**			VHSG, NGOs, **Kanta Bopha**
23.3	Reproductive, maternal & neonatal health and nutrition, including PMTCT, family planning, nutrition, ANC, PNC, facilities based delivery, new born health checks	Constitution Article 72 (rural maternities), Ank 67, Prakas 308 (central/PHD structures not functions)	MPA & CPA GD 2007; HSP2; many reprod & maternal healthpolicies & GD	Urban maternity services not legally mandated except NCMCH	**NCMCH**	**PRH**	**OD,RH, HCs**			VHSG, CBD, NGOs, private pharmacies
D. Health Finance Functions										
25	**Subsidized health insurance for the poor**									
25.1	HEFs		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	donor-supported pilots in most RHs and a third of HCs	**MOH DPHI (policy), HSSP2 secretariat (contracting), MOP (ID Poor)**		CBO (j)	CBO board	CBO board	**NGOs,DP**
27	**Social Health Insurance for Civil Servants and management of the National Social Security Fund for Civil Servant (NSSF-C)**		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	Draft law exists; MOSAVY is planning NSSF-C SHI scheme	**MOSAVY** developing mandate & establishing NSSF-C,MOH DOP on Board					
28	**Voluntary health insurance**									
28.1	CBHI		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	DP-supported pilots in few districts	**MOH, DPHI**		CBO (j)	CBO board	CBO board	NGOs
29	**Vouchers for health services**		Health Financing Charter, 1996; donor project GDs	DP-financed pilots in few districts	**NMCHC**					NGOs
30	**Conditional cash transfers (e)**		National Social Protection Strategy	donor-financed pilots in few districts	**MOI** lead implementer; MOH input on supply side		CBO (k)	CBO board	CBO board	NGOs

IV. Master-List of Key Functions and Sub-Functions

Table 5 below presents a master list of the functions and major sub-functions of the MOH, the legal bases for each of these functions. This table synthesizes functions from tables 2-4. Table 5 groups the functions of the Ministry into five major categories based on the conceptual map of functions introduced in Table 1. This list of functions and associated legal documents, strategy and policy documents has been validated by consultation with the central departments, centres and institutes of the MOH and designated representatives of the PHDs.

V. Mapping of Functions to Levels of Administration

Table 5 also shows the mapping of the functions and major sub-function in the MOH master list to different levels of administration within the MOH, and to levels of sub-national administration and the private sector where applicable. Unlike other sectors, the MOH has an additional level of administration – the OD level – that is positioned between the province level and the sub-national administrative district/municipality (D/M) level. An additional column is included in Figure 5 for the OD level. This mapping has been validated by consultation with the MOH central departments, centres, designated representatives of the PHDs and a sample of ODs, SNA representatives and DP representatives.

In accordance with the NCDD-S's Guideline on Functional Mapping, the functional mapping tables maps all the central functions of the MOH as well as the sub-national functions. As with MOH's all over the world, the central level of the MOH has more specialized and differentiated functions than the province and district levels of the Ministry. This adds to the complexity of the functional mapping. The list of functions relevant to sub-national level is shorter and simpler. In the next stage of the Functional Review, it may be helpful to focus on this shorter and simpler list of functions and set aside further consideration of the specialized central functions.

It is noteworthy that many functions of the MOH are **joint** functions of central MOH, PHD and OD. Table 2 uses bold typeface to indicate which level of administration has the main decision-making responsibility for each function. **Joint functions and linkages between levels of the health system** are an important characteristic to understand and take into account in functional review. In Cambodia, as in other countries, specialized expertise at higher levels of the system is used to provide technical guidance, advice and training to lower levels of the system. Higher levels of the system also provide coordination to manage issues such as communicable disease outbreaks or other public health emergencies that can have "spill overs" between districts or provinces. In curative health service delivery, local primary care level refers complex cases to hospitals of progressively higher levels of specialization at district, province and national level.

Table 5: MOH Functions Master-List: Mapping of Current Functions to Administrative Levels (1)

	Functions and sub-functions	Legal reference	Med. term plans, strategies, policies define functions not legally mandated	Practically implemented functions not legally mandated	Legal functions not practically implemented	National Ministry or Agency	Province	Health Operational District (a)	District/ Municipality/Khan	Commune/ Sangkat	Other
A. Policy, regulation, general management, governance											
1	**General management, leadership**	Kram 0196-06,1996;Ank 67 , 1997 on MOH mission & organization				**MOH Cab, DGs, Directors, chiefs**	PHD, PRH	OD, RH, HC			
2	**Administration and personnel management**										
	Sub-functions										
2.1	General administration	ank 67 of 1997 on MOH mission & organization				**MOH, Dep Admin; Dep Legislation**	PHD	OD			
2.2	Personnel recruitment, deployment, promotion (b)	Kram1094-006 Civil Service Law 1994				**CAR, SSCS, MOH, Dep Pers**	PHD	SOA ODs (c)			
2.3	Civil service administration, pay, discipline, ethics (b)	Kram1094-006 Civil Service Law 1994				**COM; MOH Dep Pers, Dep Legis**	PHD	OD			
2.3	Incentives financed from user fees, insurance, SOA-SDGs (d)	Ank 69, 2009, Creation of SOAs in Health; Prakas 348,1997, Pilot Health User Fees; Prakas 809,2006, Intermin. Dir. on support for poor patients				MOH Dep Personnel, DPHI; **NHs**	**PRH**	**OD; RHs;** HCs			
3	**Budget and finance**										
	Sub-functions										
3.1	Government budget and procurement (excl. drugs & vaccines logistics) (b)	Ank 81, 1995, 350 Budget and finance law ; □				**MEF**; MOH Dep Budget & Fin	**Governor, PEFD, Prov Tsy**, PHD	OD			
3.2	User fees & insurance revenue (d)	Prakas 348, 1997, pilot user fees; Prakas 809, 2006, Intermin Dir on support for poor patients; no law for HEFs	Health Financing Charter, 1996; HEF guidelines			MOH DPHI; **NHs**	**PRH**	**RH, HCs**		HCMC	
3.3	SDG (SOAs only) and PBB (SOAs and PAEs only)		SDG manual	in 22 ODs, 8 PRHs		MOH **HSSP2 secretariat; NHs**	**SOA PRHs**	**SOA ODs**			
4	**Internal Audit**	Ank 40, Ank 18 Creation & Function of Internal Audit in MOH 2006				**MOH, Dep Int Audit**					
	Sub-functions	**as above**				**as above**					
4.1	Review roles, collaboration and programs of a unit										
4.2	define appropriateness, completeness and provide good results on internal control system for accounting, administration and cooperation of the organisation										
4.3	Review on the appropriateness, timely, and clarity of the financial information and cooperation with the operation procedure for measure the grade and reporting.										
4.4	Review ing the system to ensure that policies and regulation are complied. Propose to change or improve in case public enterprises, organisation applying unappropriately										
4.5	Review on management, maintenance, and verification all properties										
4.6	Evaluation the effectiveness of using resources and provide recommendation for improvement of cooperation										
4.7	Review cooperation programs and expenditure programs for the results of positive or negative according to the objectives and goals defined and according to plan										
4.8	participate in developing plan□										
5	**Inspection & control**	Ank 67, Prakas 128, 2000,Role & Functions of Inspection & Control				**MOH DG for Inspection**					
	Sub-functions	**as above**				**as above**					
5.1	Regular control over the organisation and function of other health units										
5.2	Inspection and Investigation of the conflicts at public and private health services										
6	**Planning & health information**										
	Sub-functions										
6.1	Planning monitoring & review	Ank 67	HSP2 2008-2015, GD: Develop AOP & 3 year rolling plan; GD: Develop AOP at PHD, OD and HC,			**MOH, DPHI**	**PHD**	ODs, HCs			
6.2	Health information systems, data collection , monitoring & analysis	Prakas_Function of PHD, 26 August 1998, MoH				**MOH, DPHI**	PHD	ODs; HCs			VHSG
6.3	Planning health facility network	Circular 85, 1995, Development & Implementation of HCP for Districts & Communes; Prakas approve new health facilities	Guidelines for Strengthening District Health System 1996-2000; Health Coverage Plan			**MOH DPHI, Minister approves new facilities**	**PHD proposes plan or facility; Governor approves**	OD provides input to province			
7	**Hospitals and other medical care regulation and standard-setting (includes MPA & HCs)**										
	Sub-functions										
7.1	licensing & inspection of private health facilities (b)	Kram 1100, 2000:Licensing & Inspection of private health facilities; Prakas 041, 2002:Delegation to PHD of licensing; Prakas 034, 2011:Technical requirements for opening or closing private health facilities			Not yet possible to inspect all private facilities	**MOH, Dep Hospitals**	**PHD** + inter agency committee	OD	Inter agency committee		
7.2	Standard-setting and accreditation for public health facilities		HSP2, project documents, SDG manual	Implemented in some sites		**MOH, Dep Hospitals**					
8	**Health Infrastructure construction & management**										
	Sub-functions										
8.1	Provision of new health infrastructure (buildings, fixtures, water & sanitation)	Ank 81;				**COM,** MOH Dep of Budget & Fin	Governor approves, PHD requests	OD provides input to province	Some D/M	Some CC	NGOs, donors, WB Proct Agent
8.2	Provision of non-medical equipment (furniture, vehicles …)	Ank 67, Ank 81				**MOH Dep of Budget & Fin; HSSP2 Secterariat**	**Governor, PEFD, PHD**		Some D/M		NGOs, donors
8.3	Maintenance of health infrastructure & non-medical equipment (furniture, vehicles..)	Ank 67, Ank 81, Prakas 308				**NHs**	**PHD**	OD			
8.4	Medical equipment provision & maintenance	Ank 67, Ank 81			Medical equipment committees established in NH & PRH; not yet in OD RHs	MOH, **NHs**	PHD, **PRH**	RH			NGOs
8.5	Medical waste management	***CHECK FOR PRAKAS***				MOH, **NH**	**PRH**	**RH, HCs**			

Table 5: MOH Functions Master-List: Mapping of Current Functions to Administrative Levels (2)

	Functions and sub-functions	Legal reference	Med. term plans, strategies, policies define functions not legally mandated	Practically implemented functions not legally mandated	Legal functions not practically implemented	National Ministry or Agency	Province	Health Operational District (a)	District/ Municipality/Khan	Commune/ Sangkat	Other
9	**Food & Drugs, vaccines and commodities**										
	Sub-functions										
9.1	Regulation of pharmaceuticals manufacture, import, distribution, retail pharmacy; & food and cosmetics	Kram 0696-02,1996:Drug Management; Prakas 0211, 2006: Role and Functions of Food and Drug Control Agency				**MOH Dep Drugs, Food & Cosmetics**	**PHD** + inter agency committee	OD	Inter agency committee		Pharmacist Professional Association
9.2	Regulation of marketing of products for infant & young child feeding	Ank 133, 2005 & Prakas 61, 2007: Marketing of products for IYCF				**MOH Dep Drugs, Food & Cosmetics, NMCHC, MOC, M of Inf, M of Ind**					
9.3	drugs and commodities supply chain management; vaccine cold chain (e)	Ank 67, Ank 81				**MOH, Central Medical Store**	PHD; PRH	OD; RH; HCs			
9.4	Drug quality control testing	Kram 0696-02, 1996: Drug Management; Prakas 0211, 2006:Role & Functions of Food & Drug Control Agency				**MOH, Nat Medicine Control Lab**					
10	**Traditional medicine**	Ank 67				**MOH, NITM**					
11	**Supervising public health sector**	Ank 67, Prakas 308				**MOH** - most programs & departments	**PHD** (PRH & OD)	**OD** (HCs)			
12	**Community participation in governance**		Draft community participation policy, 2008	No MOH mandate but MOH implements in many sites					DDC (for RH)	**HCMC**	VHSG
13	**International health cooperation & aid coordination**										
	Sub-functions										
13.1	Strenthening coop & facilitate relations with national / international organizations, civil society, countries, donor agencies and private bodies supporting health sector	Ank 67, Prakas 519, 2006: organization & function of dep internat. Coop of MOH				**MOH Dep Int Coop, DPHI, HSSP2 Secretariat**	PHD	OD			
13.2	Coordinate aid programs for health through organization of TWGH, ; agreements with development partners & management units on implementation & M&E of aid programs; collection, analysis & reporting about aid activities	as above				as above	PHD	OD			
13.3	International cooperation for emerging disease control	Ank 67	Asia strategic plan for emerging diseases			**MOH, Dep CDC**					
14	**Intersectoral coordination: health advice and input on intersectoral issues related to health, disease, safety, nutrition**										
	Sub-functions										
14.1	MOH/health advice to National Addictive Drugs Committee (chaired by MOI) (g)	Not MOH mandate				**NADC, MOI** chairs; MOH participates	Province inter agency committee				
14.2	MOH/health advice to national committee on coordination of disaster management (g)	Not MOH mandate				**Nat Com for Disaster Mgt**, MOH participates	Province CDM		***CHECK if there is district committee***		
14.3	MOH/health advice for National AIDS Authority for intersectoral HIV/AIDs coordination (g)	Interministerial Prakas ***CHECK***				**NAA under COM**; MOH on board	PACC				
14.4	MOH/health advice to intersectoral coordination committee on child labor (g)	Not MOH mandate				Committee on Child Labor; MOH participate					
14.5	MOH/NNP input to intersectoral nutrition functions, incl. Nat Council for Nutrition (under MOP) and intersectoral TWG on food security under CARD, food quality under MOC & food supplementation under MOC/MOP (g)	Not MOH mandate				**Nat Council for Nutrition, TWG under CARD,** MOC/MOP, MOH participates	?				
B. Health Human Resources Development Functions											
15	**Planning, management and coordination of training for HRH**										
	Sub-functions										
15.1	System Planning, policy guidelines, legal framework, and coordination of pre-service education and in-service training; management of HRH information	Ank 67, Prakas 33 of 1998 on establishment of Dept of HRD				**MOH, Dep HRD;** MOH provides input to MOEYS for degree programs					
15.2	Setting minimum standards for management and establishment of training institution for health (public and private)	Ank 21			Enforcement of standards is not yet fully implemented	MOH HRD provides technical input, **MOEYS** mandate					
15.3	Assistance in management and coordination of the National Entrance and Exit Exams	***Check for legal reference***				**Joint MOEYS-MOH** mandate					
15.4	Management and coordination of data base training, registration and licensing of HRH	Ank 67, Prakas 33 of 1998 on establishment of Dept of HRD				**MOH, HRD**					
15.5	Management Registration and Licensing System for HRH	Kret 0200-039, 2000 on Doctors' Association; 0905-396,2005 on Dentists' Association; 0906-389, 2006 on Midwives' Association, 0807-373 on Nurses' Association; 0210-162, 2010 on Pharmacists' Association				**Doctors' Association, other health professional associations**					
15.6	Management of accredication and certification of health professionals	***Check for legal reference***	***Check for policy document***		Not yet fully implemented	**Accreditation Council of Cambodia**					
16	**Delivery of training to health workers**										
	Sub-functions										
16.1	Pre-service training delivery	Ank 67, ***CHECK for PRAKAS FOR RTCs***	HR Development Plan			**UHS, nursing school, RTCs**					private medical school
16.2	In service training delivery	Ank 67	HSP2, ???HR Devpt Plan			**MOH, many departments deliver cascade training**	PHD	OD			NGOs
16.3	Non-medical capacity development; including capacity development of community workers	Ank 308; Ank 51 gives mandate to MRD to train community health workers	Comm Participation Policy, 2008	No MOH mandate but MOH implements in many sites		MRD, Dep Rural Healthcare		**OD, HCs**			NGOs

Table 5: MOH Functions Master-List: Mapping of Current Functions to Administrative Levels (3)

	Functions and sub-functions	Legal reference	Med. term plans, strategies, policies define functions not legally mandated	Practically implemented functions not legally mandated	Legal functions not practically implemented	National Ministry or Agency	Province	Health Operational District (a)	District/ Municipality/Khan	Commune/ Sangkat	Other
C. Health Service Delivery Functions											
17	**Primary care: basic health service delivery (MPA)**										
	Sub-functions										
17.1	Primary care service delivery	Constitution Art.72, Prakas 120, 1996: Organization of the District Health Office	Guide for Strengthening the District Health System, 1997; MPA GD, 2007	Urban HCs/MPA not mandated but MOH implements				**OD, HCs (h)**			VHSG, NGOs
17.2	Community mobilization and participation in primary health services	Ank 51 gives MRD mandate to mobilize rural community participation in health	Draft community participation policy, 2008	No MOH mandate but MOH implements in many sites						HCMC	**VHSG, NGOs**
18	**Hospital and specialist care** in national specialist hospitals, CPA 3 provincial referral hospitals, CPA 2 and CPA 1 district referral hospitals	Ank 67, Kret 1296-94, 1996 Calmette establ as PAE; Ank 96, 2009 estab other NHs as PAEs; Ank 69, 2009 estab some PRH as SOA	Guide for Strengthening the District Health System, 1997; CPA GD, 2007	RH network/CPA not mandated but MOH implements, subject to resources available		**NH, Kantha Bopha**	**PRH, CPA3**	**RH, CPA1 or CPA2**			NGOs, private clinics
19	**Blood transfusion & blood bank services including regulation of blood donation & blood products**	Prakas 01, 1994: Blood transfusion & blood safety				**NCBT, NH**	**PRH**				
20	**Emergency transport to health facility**										
	Sub-functions										
20.1	Ambulance & health facility to facility transport		CPA GD, 2007	Not mandated but MOH implements		**NH**	**PRH**	RH			Private sector
20.2	Village to health facility		Comm Participation Policy, 2008	Limitted implementation				RH		some CCs ?	VHSG, HEFs
21	**Communicable disease control (i)**										
	Sub-functions										
21.1	HIV/AIDS prevention	Kram 0702-012, 2002: Prevention of AIDS; Ank 67 (central structure not functions)	HSP2 & HIV/AIDs strategy, policies & GD			**NCHADS, NAA**	PHD	OD, RH, HCs			NGOs
21.2	HIV/AIDs testing, counselling, treatment and care	Kram 0702-015, 2002; Ank 67 (central structure not functions)	as above			**NH**	**Clinic at PRH**	**Clinic at RH**			Private sector
21.3	TB prevention & awareness raising	Ank 70, 1995: Nat Com for TB; Ank 67 (central structure not functions)	HSP2 & TB control strategy, policies & GD			**CENAT**	PHD	OD, HCs			NGOs
21.4	TB diagnosis & treatment (treatment at subnational level is included in MPA & CPA)	Ank 70, 1995: Nat Com for TB; Ank 67 (central structure not functions)	as above			**CENAT, NH**	**PRH**	**RH, HCs**			**Village health workers**
21.5	Malaria, dengue & other parasitic disease prevention & vector control (treatment is included in MPA & CPA)	Ank 67 (central structure not functions)	HSP2,malaria control strategy, malaria & dengue policies & GD			**CNM**	PHD	**OD, HCs**			**Village Malaria Workers**
21.6	Avian influenza and other animal-human disease control (treatment is included in CPA)	Falls under CDC in general in Ank 67 & Prakas 308	as above			**MOH Dep CDC, MAFF**	**PHD, PAFD**				
21.7	Other communicable diseases (treatment is included in MPA, CPA)	Ank 67, Prakas 308				**MOH, Dep CDC**	**PHD**	OD, HCs			VHSG
22	**Non-communicable disease control (h)**										
	Sub-functions										
22.1	NCDs including diabetes management and road traffic injury prevention (treatment is included in MPA, CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	CPA GD, 2007	NCD treatment not legally mandated	Limited implementation	**MOH, Dep Prev Med**	PHD, PRH	OD			VHSG, peer educators, NGOs
22.2	Mental health (treatment is included in CPA)	Falls under Preventive Med & Health promotion in Ank 67, Prakas 308	CPA GD, 2007	NCD treatment not legally mandated	Implementation subject to resources	**NH**	**PRH**				NGOs
23	**Maternal, reproductive and child health (h)**										
	Sub-functions										
23.1	abortion services regulation	Kram 1197-06,1997: Abortion Law				**MOH, NMCHC**					
23.2	Child health & nutrition including immunization, well child checks,management of malnutrition, integrated management of childhood illness and CDD-ARI	Ank 67, Prakas 308 (central/PHD structures not functions)	MPA & CPA GD 2007; HSP2; many child health strategy, policy & GD	Nutrition not MOH mandate but MOH NNP implements some activities		**NCMCH, NIP, NNP**	**PHD, PRH**	**OD, RH. HCs**			VHSG, NGOs, **Kanta Bopha**
23.3	Reproductive, maternal & neonatal health and nutrition, including PMTCT, family planning, nutrition, ANC, PNC, facilities based delivery, new born health checks	Constitution Article 72 (rural maternities), Ank 67, Prakas 308 (central/PHD structures not functions)	MPA & CPA GD 2007; HSP2; many reprod & maternal healthpolicies & GD	Urban maternity services not mandated except NCMCH but MOH implements		**NCMCH**	**PRH**	**OD,RH, HCs**			VHSG, CBD, NGOs, private pharmacies
24	**Disease prevention (primary prevention), health promotion and public health education in non medical settings (h)(Also integrated into** functions 17 and 21-23)	Constitution Art 72; Ank 67; Prakas 308	HSP2; MPA GD; strategy & policy GDs for vertical programs, community participation policy			**MOH NCHP & CDC Center & NMCHC**	**PHD**	**OD, HCs**			VHSG

Table 5: MOH Functions Master-List: Mapping of Current Functions to Administrative Levels (4)

	Functions and sub-functions	Legal reference	Med. term plans, strategies, policies define functions not legally mandated	Practically implemented functions not legally mandated	Legal functions not practically implemented	National Ministry or Agency	Province	Health Operational District (a)	District/ Municipality/Khan	Commune/ Sangkat	Other
D. Health Finance Functions											
25	**Subsidized health insurance for the poor**										
25.1	HEFs		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	donor-supported pilots in most RHs and a third of HCs		**MOH DPHI (policy), HSSP2 secretariat (contracting), MOP (ID Poor)**		CBO (j)	CBO board	CBO board	**NGOs ,DP**
25.2	SUBO	Prakas 809 of 2006: Interministerial directive on support for poor patients			NHs, some PRH and RHs w here HEF does not cover all poor	**MOH Dep Budget & Fin, NH**	PRH	RH, few HCs			
26	**Social Health Insurance for Private formal Sector. Mandatory contributory social health insurance and management of the NSSF**	Kram 0902-012, 2002: establishing NSSF			SHI planned, not yet implemented; w orkers compensation implemented in 7 provinces	MOH, DPHI on NSSF board; **MOL Mandate, NSSF**	NSSF office				
27	**Social Health Insurance for Civil Servants and management of the National Social Security Fund for Civil Servant (NSSF-C)**		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	Draft law ; MOSAVY is planning implementation for civil servants		**MOSAVY** developing mandate & establishing NSSF-C,MOH DOP on Board					
28	**Voluntary health insurance**										
	Sub-functions										
28.1	CBHI		National Social Protection Strategy; draft Social Health Protection Masterplan; draft Health Financing Policy	No law : donor-supported pilots in few districts		**MOH, DPHI**		CBO (j)	CBO board	CBO board	NGOs
28.2	PMI	Kram, 2000 on Insurance (in general)				**MEF**					private sector
29	**Vouchers for health services**		Health Financing Charter, 1996; donor project GDs	donor-financed pilots in few districts		NMCHC					NGOs
30	**Conditional cash transfers (e)**		National Social Protection Strategy	donor-financed pilots in few districts		MOI lead implementer; MOH input on supply side		CBO (k)	CBO board	CBO board	
E. Health Research Functions											
31	**Health research**										
	Sub-functions										
31.1	Ethical approval for medical research	***CHECK if there is a PRAKAS***				MOH Ethical Committee					
31.2	Commission & conduct research	Ank 67, Prakas 308			PHDs do not conduct research	MOH,1; NIPH,1; UHS,1	PHD				NGOs, 2; private sector, 3

VI. Mapping of MOH Personnel and Health Facilities to Organizational Units and Functions

Figure 1 shows the organizational structure of the MOH according to Ank. 67 and later sub-decrees that have changed its organization chart.

At province and district level, the MOH adopts different models of organization in different geographies – for example in remote, sparsely populated areas, in "typical" rural areas, and in provincial towns and urbanized areas. **This suggests there may be a need to consider asymmetric functional transfers during the functional review.**

A particularly important document for functional mapping in the health sector is the **Health Coverage Plan** (HCP) which was formulated in 1994-1996, based on the authority of MOH Circular 85 of (1995). The HCP describes the reformed organization of public health services and facilities at province, district and commune level that was implemented in 1996. Each of the 23 provinces and the Capital Phnom Penh has a provincial health department, with responsibilities that map to the territory of the SNAs at province level and in the Capital. But the HCP reformed the organization of health responsibilities within the province. The HCP used a combination of criteria for planning the health facilities network to ensure coverage of the whole country with essential health services. The criteria were based on the minimum population size needed to achieve economies of scale in health service delivery and on accessible distance/travel time for the population to health facilities. Criteria for primary care services (the "Minimum Package of Activities"(MPA)) and for referral hospital (RH) services (the "Complementary Package of Activities" (CPA)) - are summarized in the table below. Primary care services are delivered through health centres (HCs) – traditionally called "infirmaries", health posts (HPs) in remote areas and through village outreach by HC staff. Referral hospital services are delivered in Operational District hospitals and provincial hospitals.

Health Coverage Plan Criteria

Criteria	Population	Accessibility
Health Centre (MPA)	Optimal: 10,000 Range: 8,000-12,000	Radius: 10 km Or Max. 2 hours walk
Referral Hospital (CPA)	Optimal: 100,000-200,000 Range: 60,000-200,000+	20-30 km between 2 RHs Or Max. 3 hrs by car/boat

The reform changed the old policy of establishing one infirmary per commune and one referral hospital per SNA district/municipality. Instead, it sets minimum population and distance criteria for health centres (the new name for infirmaries) and referral hospitals for efficient, accessible health service delivery. Based on this prakas, the **MOH organizes its sub-national health services into 77 Operational Districts (OD) based on the catchment areas of a district Referral Hospital** (RH). One OD usually covers 2-3 SNA districts/municipalities (D/Ms), though in a number of cases the boundaries of an OD may include only part of some D/Ms. Figure 6 shows a map of MOH OD boundaries alongside SNA boundaries, illustrating the mismatch between MOH OD boundaries and SNA D/M boundaries.

Figure 2 shows the organization chart of a typical PHD. Typical PHDs are divided into more than one OD. Figure 2 also indicates a range of the approximate number of staff found in each of the functional units within the PHD. The same structure is found in the Phnom Penh Health Department, which is at an equivalent level in the MOH hierarchy to a PHD. However, the Phnom Penh Health Department has some unique features for several reasons. Firstly, many Phnom Penh citizens access

services from national referral hospitals under the direct supervision of the MOH and from the large private sector in the Capital. Secondly, many residents of the nearby provinces surrounding Phnom Penh come to the city to access services, for example, because they may work in the city and use health services while they are there. Unregistered urban slum communities create specific needs as well (though this is also true in some other provinces).

In some provinces, the PHD is not divided into multiple ODs – these are called "Single-OD PHDs". In these provinces, the PHD combines the functions of PHD and OD into one office. Figure 3 shows the organization chart for this type of PHDs and indicates approximate numbers of staff in each function. This organizational model was adopted in remote provinces with a small population (Oddar Meanchey, Preah Vihear, Stung Treng, Rattanakiri and Mondulkiri) where there are not enough population to support more than one hospital. Where a Special Operating Agency (SOA) has been established in a single OD-PHD there are further differences. In these cases (in Oddar Meanchey, Preah Vihear, Rattanakiri and Mondulkiri), the PHD is divided into a PHD office which supervises the SOA, and a separate SOA-OD office that manages hospital and primary care services for the whole province. The "single-OD PHD" organizational model was also adopted in provinces with a small territory (Pailin, Kep, Sihanoukville), because the small territory means that PHD office and provincial hospital can easily cover the whole province. There are economies of scale in consolidating the hospital services in these provinces into one hospital with a wide range of services.

Figure 4 shows the organization chart of a typical OD level and indicates the approximate number of staff assigned to each function in the OD office. It is noteworthy that at OD level in particular, there is a high level of multi-tasking by most staff. It is also noteworthy that some functions at PHD and OD level are only a part time activity of one or two staff. Interviews conducted in field work identified that OD office staff and HC staff typically work in teams to carry out tasks such as integrated supervision and integrated outreach. This has important implications for the functional review, because it means that these **integrated team activities should be kept together to the fullest extent possible in any functional transfers.**

A different model of organization is adopted for ODs located in the same town as the provincial administration and PHD. In these cases, the OD does not have its own referral hospital because the Provincial Referral Hospital (PRH) is located in the town and provides RH services for the OD population as well as more specialized hospital services for patients referred from other OD RHs in the rest of the province. The PRH is directly supervised by the PHD. Figure 5 shows the organization chart of a typical OD office located in the provincial town.

Future Changes in Organization of PHDs and ODs

In future, the MOH plans to divide some of the single-OD PHDs (Oddar Meanchey, Preah Vihear, Stung Treng, Rattanakiri and Mondulkiri) into two or more ODs. This change is in response to growing population, and also to growing health human resource capacity to staff additional OD offices, district hospitals and health centres.

Figure 1: Organization Chart of the Ministry of Health

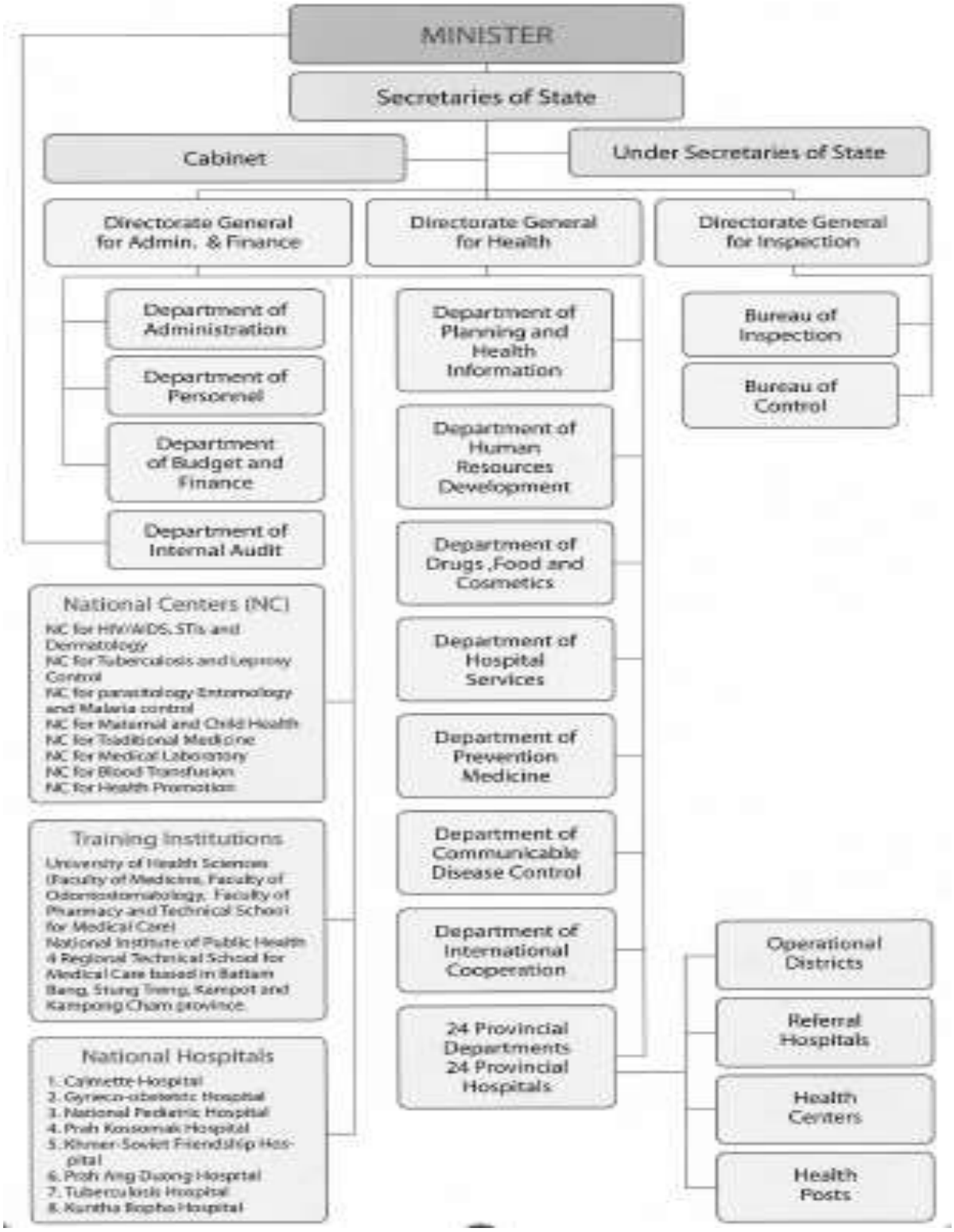


Figure 2: Organization Chart of the Capital & Typical Provincial Health Departments

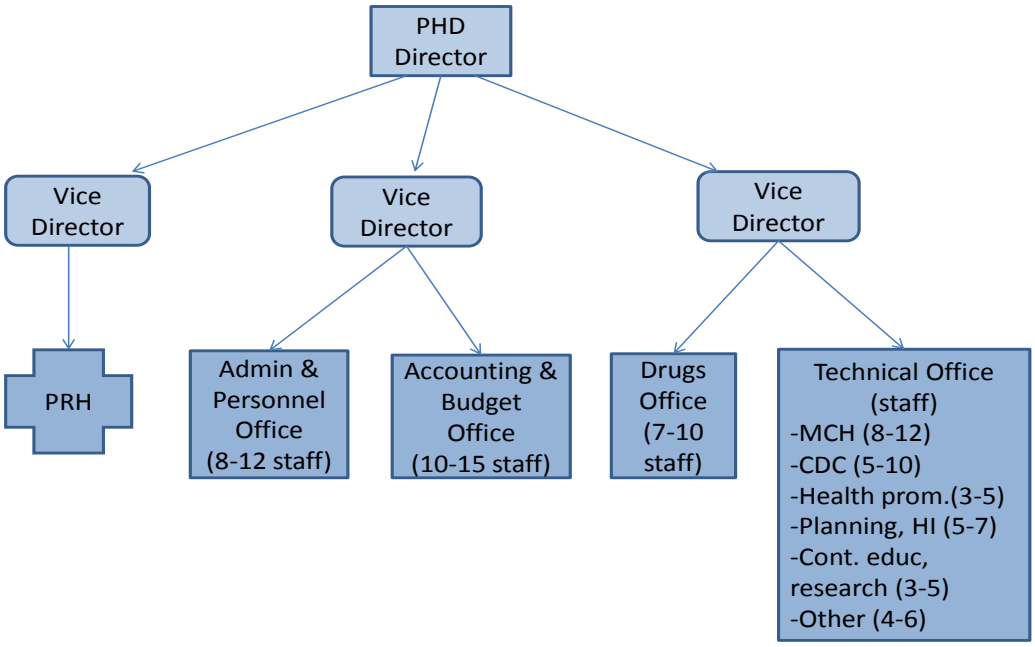


Figure 3: Organization Chart of Provincial Health Departments with Single Operational District

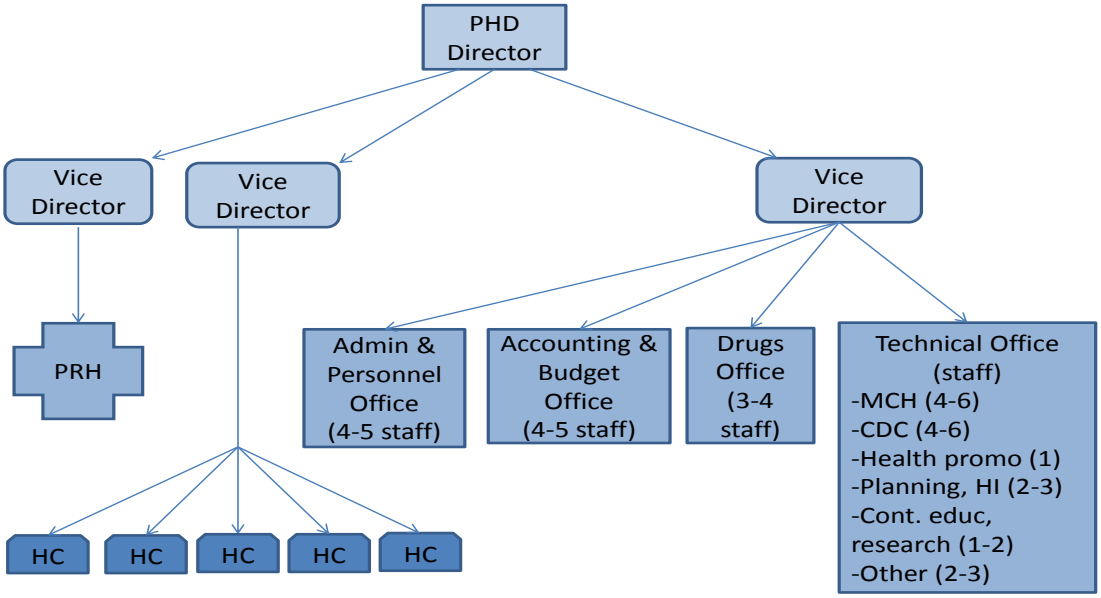


Figure 4: Organization Chart of Typical Health Operational District

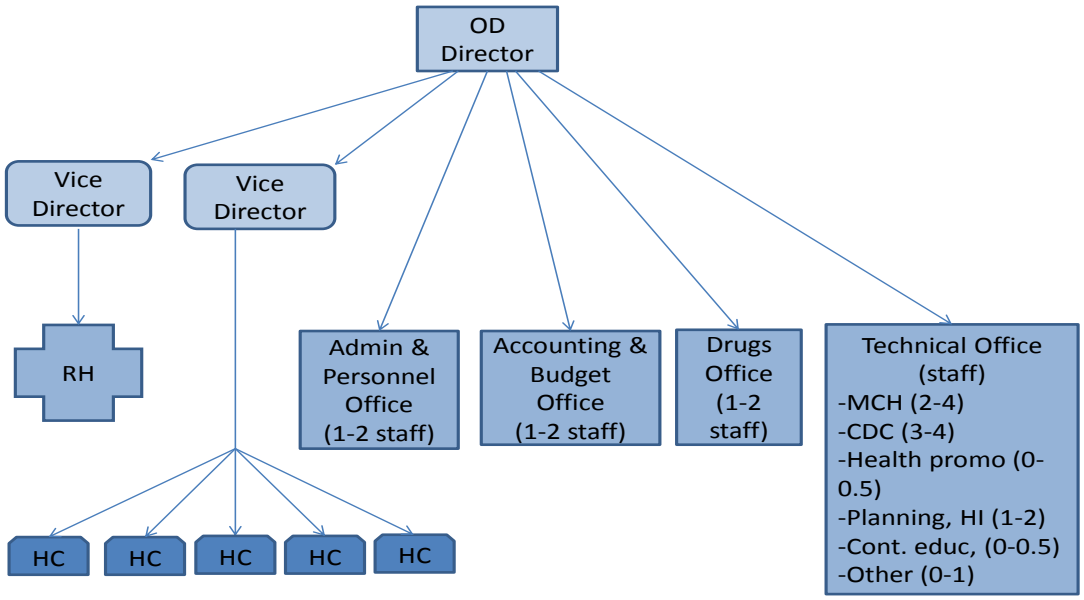
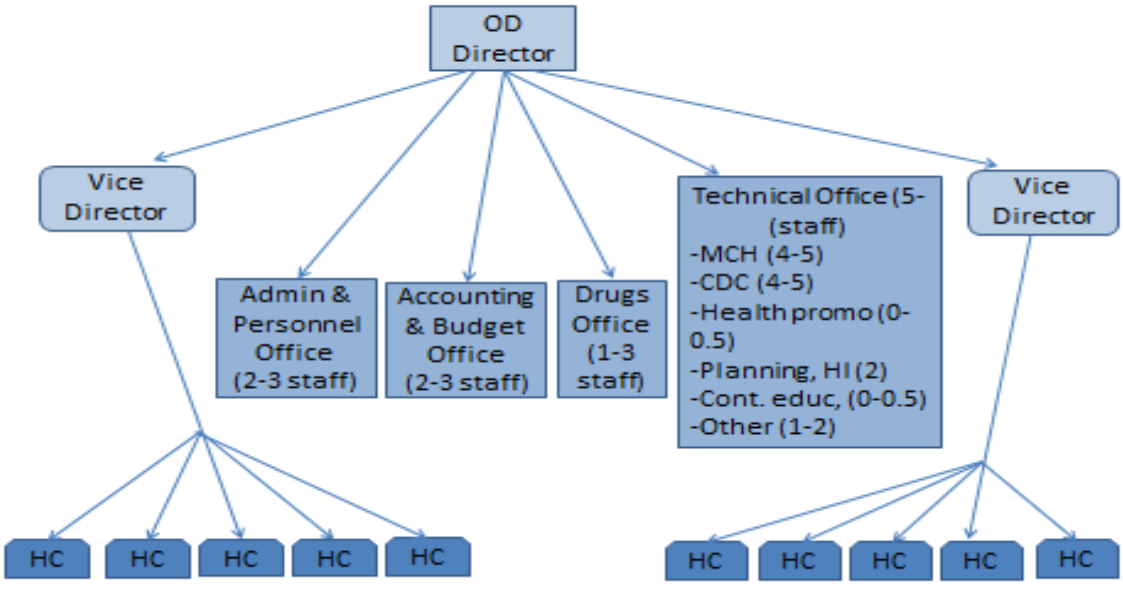


Figure 5: Organization Chart of Health Operational District at Province Town (city or town where provincial administration is located)



Mapping MOH Personnel

Figure 6.1 summarizes the number of MOH personnel by professional profile in each of the MOH's organizational units, including central level departments, National Hospitals, National Centres and Institutes, Regional Training Centres (RTCs), Provincial Health Departments (PHDs) and the Phnom Penh Municipal Health Department, ODs and health facilities.

Figure 6.2A maps the MOH central level personnel to the functions in the master list. In this and the following personnel mapping tables, personnel are mapped groups of functions in cases where it is not easily possible to disaggregate the personnel mapping by detailed functions.

Figure 6.2B maps PHD personnel to major groups of functions, aggregating across all PHDs and the Phnom Penh Municipal Health Department. Note that this table includes staff in the PHD office and the PRH. It does not include the staff of the ODs in the provinces, although officially the ODs are part of the PHD structure.

Figure 6.2c maps personnel to functions for ODs, including OD office staff, RH and HC staff. This table aggregates for all ODs in the country except for staff in the PHD office and PRH of the single-OD PHDs. It does however including the HC and HP staff of these provinces.

Explanatory notes on personnel data tables

Please note that it is not possible to obtain disaggregation of personnel data by cadre level (A,B,C,D) from the MOH personnel data base. This information could be requested from the payroll databases of CAR, when required. A more detailed disaggregation of MOH personnel data by health professional type (specialist, doctor, nurse, midwife, etc.) is available and is supplied in a spread sheet annexed to this report.

Some data totals in the tables may not fully reconcile because some data is derived from MOH personnel data base in May 2012, and other data is derived in September 2012. An increase in personnel occurred between these dates, particularly at sub-national level.

Incentives paid to MOH staff at central level and subnational level through Priority Operating Costs (POC) have been phased out since June 2012, except for POC payments from the Global Fund which will cease in December 2012. The only remaining salary incentives received by MOH personnel are as follows:

- Distribution of 60% of user fee, HEF and other health insurance revenues to staff in health facilities, with a share also going to staff in OD and PHD offices;
- SDG incentives paid to staff in SOAs, financed by HSSP2;
- Distribution of some non-budget income from fees and sales of services in teaching and research institutions.

FIGURE 6.1 DETAILED GOVERNMENT PERSONNEL DATA OF MINISTRY OF HEALTH BY UNIT/ORGANIZATIONAL STRUCTURE (1)

				Educational Qualifications (a)				Personnel by Cadre			
				1	2	3	4	A	B	C	D
	TOTAL STAFF Sept 2012	Female Staff Sept 2012	Female staff as % of total staff Sept 2012	Total Unskilled	Total Secondary	Total Tertiary	Total Post-Graduate	Data not available from MOH databases			
Central MOH Departments											
MoH Leadership	5	1	20		0	5	0				
Cabinet	5	1	20		0	5	0				
Dep Administration	32	11	34	3	7	21	0				
Dep Budget and Finance	69	18	26	16	5	51	0				
Dep Communicable Disease	68	12	18	2	9	56	0				
Dep Drug Food and Med Equipment	73	27	37	3	5	65	0				
Dep Planning & Health Information	30	13	43		4	24	3				
Dep Hospitals	50	15	30		12	37	1				
Dep Human Resources	24	10	42		6	18	0				
Dep Internal Audit	22	3	14		1	21	0				
Dep International Cooperation	12	5	42	1	0	11	0				
Dep Personnel	28	7	25	2	6	20	0				
Dep Preventive Medicine	26	11	42		5	21	0				
General Directorate for Admin & Finance	4	2	50		0	4	1				
General Directorate for Health Technical	16	10	63	3	6	6	1				
Inspectorate	11	1	9		2	10	0				
National Hospitals											
Calmette Hosp	508	251	49	10	25	451	20				
Khmer-Soviet Friendship Hosp	533	246	46	12	73	441	4				
Kantha bopha Hosp (legacy civil servants)	164	95	58		12	152	3				
National Pediatric Hosp	369	167	45	8	20	329	2				
Preah Ang Doung Hosp	132	66	50	3	15	109	0				
Preah Kossamak Hosp	375	164	44	7	49	303	2				
National Centers & Institutes											
Cambodia Red Cross (legacy civil servants	19	7	37	11	3	5	0				
Central Medical Store	41	11	27	7	10	17	0				
Nat Center for TB and Leprosy	159	74	47	5	22	136	0				
Nat Center for HIV AIDS	119	47	39	8	13	100	0				
Nat AIDS Authority	26	8	31	1	5	20	0				
Nat Center for Health Promotion	48	19	40		10	37	0				
Nat Center for Blood Transfusion	49	24	49	2	4	33	0				
Nat Center for Malaria	94	40	43	6	14	73	0				
Nat Center for Traditional Med	31	11	35	1	9	21	0				
Nat Institute for Public Health	79	31	39	2	7	72	0				
Nat Center for Medical Laboratory	37	25	68	1	3	33	1				
Nat Mother & Child Health Center	327	218	67	11	46	261	0				
Pasteur Institute (legacy civil servants)	28	19	68	2	5	23	0				
Nursing School	87	52	60	1	6	75	0				
University of Health Science	124	41	33	2	11	103	5				
Regional Training Centers											
RTC Battambang	47	24	51	3	2	42	0				
RTC Kampong Cham	38	24	63	1	2	31	0				
RTC Kampot	46	21	46	1	2	40	0				
RTC Stung Treng	29	12	41	1	1	24	0				

FIGURE 6.1 DETAILED GOVERNMENT PERSONNEL DATA OF MINISTRY OF HEALTH BY UNIT/ORGANIZATIONAL STRUCTURE (2)

	TOTAL STAFF Sept 2012	Female Staff Sept 2012	Female staff as % of total staff Sept 2012	Total Unskilled	Total Secondary	Total Tertiary	Total Post-Graduate	Data not available from MOH databases				Number of personnel receiving incentives
PHDs and Phnom Penh Health Dep												**(d)**
Phnom Penh	717	383	53	10	241	418	1					670
Banteay Meanchey	986	431	44	65	384	463	0					912
Battambang	1444	708	49	118	508	766	1					1393
Kampong Cham	1566	726	46	34	552	835	2					1423
Kampong Chhnang	595	329	55	9	297	250	1					557
Kampong Speu	790	362	46	10	363	381	1					755
Kampong Thom	681	374	55	89	275	269	0					633
Kampot	931	535	57	83	293	476	1					853
Kandal	1145	594	52	53	392	641	2					1088
Kohkong	210	82	39	4	52	119	0					175
Kratie	615	328	53	14	302	236	0					552
Kep	112	50	45	2	38	62	0					102
Pailin	157	67	43	13	60	62	0					135
Mondol Kiry	190	93	49	11	81	79	0					171
Oddor Meanchey	254	81	32	1	122	101	0					224
Preah Vihear	353	152	43	9	145	134	0					288
Prey Veng	1118	441	39	52	606	371	1					1030
Pursat	535	234	44	17	152	357	0					526
Rattanak Kiry	322	109	34	11	149	124	1					285
Siem Reap	808	429	53	11	296	437	0					744
Preah Sihanouk	320	155	48	7	92	203	0					302
Stung Treng	306	150	49	14	126	128	0					268
Svay Rieng	519	227	44	7	270	209	1					487
Takeo	1184	570	48	19	407	645	2					1073
TOTAL STAFF NUMBERS	**19842**	**9976**	**50**	**799**	**6640**	**11072**	**57**					**18640**

TABLE 6.2A: LIST OF GOVERNMENT PERSONNEL BY FUNCTION of UNIT/DEPARTMENT AT CENTRAL LEVEL

		TOTAL STAFF	Qualifications (a)				Personnel by Cadre				Number of Personnel Receiving Incentives (b)
			1	2	3	4	A	B	C	D	
			Total Unskilled	Total Secondary	Total Tertiary	Total Post-Gradua	Data not available from MOH databases				
Function មុខងារ											
Policy, regulation, administration, governance ("back office functions")											
1	Setting strategy & strategic policy បង្កើតគោលនយោបាយ និងកំណត់យុទ្ធសាស្ត្រ	26	3	6	15	2					0
2	General management, leadership ការគ្រប់គ្រងទូទៅ ដឹកនាំ	31	3	6	20	2					0
3	Administration and personnel management រដ្ឋបាល និងបុគ្គលិក	59	5	13	41	0					0
4	Budget and finance (includes procurement and logistics, except drugs & vaccines) ថវិការ និងការផ្គត់ផ្គង់ (មិនបញ្ចូល ឱសថ និង វ៉ាក់សាំង)	72	16	5	51	0					0
5	Internal Audit សវនៈកម្មផ្ទៃក្នុង	22	0	1	21	0					0
6	Inspection & control អាជ្ញាធិការដ្ឋាន	12	0	2	10	0					0
7	Planning & health information ផែនការ ពាក់ព័ន្ធសុខាភិបាល	24	0	4	20	0					0
8	Hospitals and other medical care regulation and standard-setting (includes MPA & HCs) មន្ទីរពេទ្យ និង ផ្ទះដ្ឋានសុខាភិបាលផ្សេងៗទៀត	50	0	12	37	1					0
9	Health infrastructure management ការគ្រប់គ្រងហេដ្ឋារចនាសម្ព័ន្ធសុខាភិបាល		*Carried out by same team as sub-function 8.*								0
10	Drugs, vaccines and commodities ឱសថ វ៉ាក់សាំង និង បរិក្ខាពេទ្យ	107	10	15	82	0					0
11	Traditional medicine ឱសថបូរាណ	31	1	9	21	0					0
12	Supervising public health sector ការអភិបាលវិស័យសុខាភិបាលសាធារណៈ										0
13	Community participation in governance ការចូលរួមរបស់សហគមន៍ ក្នុងអភិបាលកិច្ច										0
14	International health cooperation & aid coordination សហប្រតិបត្តិការអន្តរជាតិ	12	1	0	11	0					0
15	Intersectoral coordination: health advice and input on intersectoral issues related to health, disease, safety, nutrition										0
Health Human Resources Development Functions											
16	Planning, regulation, management and delivery of training for HRH ផែនការគ្រប់គ្រង និងសម្របសម្រួលការបណ្តុះ បណ្តាលធនធានមនុស្សសុខាភិបាល	730	0	30	686	5					235 (c)
17	Other capacity development ការអភិវឌ្ឍន៍សមត្ថភាពផ្សេងៗទៀត										0
Service Delivery Functions											
18	Primary care: basic health service delivery (MPA) សំណុំសកម្មភាពអប្បរមា										
19	Hospital and specialist care សំណុំសកម្មភាពបង្ការ និងមន្ទីរពេទ្យជាក់	2088	41	197	1818	32					2088 (d)
20	Blood transfusion & blood bank លោហិតសាស្ត្រ	58	13	7	38	0					
21	Emergency transport to health facility សេវាកិលាន សង្គ្រោះ										
22	Communicable disease control (i); កម្មវិធីជំងឺឆ្លង	470	22	63	385	0					
23	Non-communicable disease control (h) កម្មវិធីជំងឺមិនឆ្លង	26	0	5	21	0					
24	Maternal, reproductive and child health (h) កម្មវិធីសុខភាពមាតា សុខភាពបន្តពូជ និងសុខភាពកុមារ	318	11	46	261	0					up to 318 (d)
25	Disease prevention, health promotion and public health education (h) លើកកំពស់សុខភាព និង ការអប់រំសុខភាពសាធារណៈ	47	0	10	37	0					
Health Finance Functions											
26	Subsidized health insurance for the poor ការឧបត្ថម្ភ ធានារ៉ាប់រងសុខភាពសំរាប់ជនក្រីក្រ	7		0	4	3					0
27	Mandatory contributory social health insurance ធានារ៉ាប់រងសុខភាពសង្គម ដោយការចូលរួមជាកាតព្វកិច្ច										0
28	Voluntary health insurance ធានារ៉ាប់រងសុខភាព ដោយស្ម័គ្រចិត្ត										0
29	Vouchers for health services កម្មវិធី បំណុលបង់ជ្រាក់ សំរាប់សុខភាព	0	0	0	0	0					0
30	Conditional cash transfers (e) ការបង្វែរសាច់ប្រាក់ដោយ លក្ខ័ណ្ឌ	0	0	0	0	0					0
Health Research Functions											
31	Health research ការសិក្សា ស្រាវជ្រាវ សុខភាព	111	4	12	95	0					111 (c)
	TOTAL CENTRAL STAFF	4301	139	435	3674	45					2752

TABLE 6.2B: LIST OF PERSONNEL BY FUNCTION of CAPITAL/PROVINCIAL HEALTH DEPARTMENT or UNIT

		TOTAL STAFF	Qualifications (a)				Personnel by Cadre				Number of Personnel Receiving Incentives (b)
			1	2	3	4	A	B	C	D	
			Total Unskilled	Total Secondary	Total Tertiary	Total Post-Gradua	Data not available from MOH databases				
Function មុខងារ											
Regulation, administration, governance ("back office functions") of the Capital Health Dept and PHDs											
1 to 17	PHD office functions include regulation, admin & finance, supervision, training…	1709	143	268	1291	7					up to 1709
Service Delivery Functions ផ្តល់សេវា											
19	Hospital and specialist care & ambulance (CPA 3)	3087	353	322	2189	223					up to 3087
	TOTAL PROVINCE-CAPITAL STAFF	4796	139	590	3480	230					up to 4796

TABLE 6.2C: LIST of PERSONNEL BY FUNCTION OF MOH OPERATIONAL DISTRICTS

		TOTAL STAFF	Qualifications (a)				Personnel by Cadre				Number of Personnel Receiving Incentives (b)
			1	2	3	4	A	B	C	D	
			Total Unskilled	Total Secondary	Total Tertiary	Total Post-Gradua	Data not available from MOH databases				
Function មុខងារ											
Regulation, administration, governance ("back office functions") of Health Operational District Offices											
1 to 16	OD office functions include regulation, admin & finance, supervision, training…	1792	161	617	1011	3					1792
Service Delivery Functions ផ្តល់សេវា											
17	Primary care service delivery (MPA)	7076	0	4347	2729	0					7076
18	Hospital and specialist care & ambulance (CPA 1 or 2)	1726	353	359	1314	18					1726
	TOTAL OPERATIONAL DISTRICT STAFF	10594	139	5323	5054	21					10594

Future Changes in MOH Personnel

The MOH's Coverage Plan sets staffing standards for HPs, HCs of different types and RHs of three different levels: district RHs without surgical capacity (CPA1), district RHs with surgical capacity (CPA2) and PRHs (CPA3 level). These staffing standards are set out in Annex 1. The MOH does not yet have sufficient budget or civil service quota posts to fully staff all of its health facilities to these

standards. In recent years, the MOH has given priority to using its additional quota to deploy midwives in sub-national health facilities as part of the RGC's commitment to reducing maternal and neonatal mortality. Fieldwork for functional mapping identified that there is variation across provinces and ODs in the shortfall between actual staffing and the staffing standard. In particular, many PHDs have not yet been able to deploy secondary midwives to remote area HCs. There are also some examples of HCs with staffing levels higher than the standard – usually in cases where the HC used to be a district hospital prior to the 1994-1996 health reforms.

In addition, the MOH has projected the need for increased numbers of health facilities and increased staffing to meet the needs of the growing population, until 2020. A summary of this projection is attached in Annex 2. This projection is updated periodically. Finally, the MOH intends to undertake a review and update of the Health Coverage Plan before 2015 which may lead to some revisions to the projected staffing requirements in each facility, district and province.

Mapping MOH Facilities

Figure 6 maps MOH PHDs and ODs alongside SNA boundaries. Annex 3 provides this mapping information in spread sheet format. MOH has one PHD office and one PRH in every province, and boundaries are aligned at province level. At OD level, only 9 of 77 ODs map exactly to an SNA district. Most ODs cover 2-3 SNA D/Ms. In more sparsely populated areas, one OD covers as many as 9 SNA D/Ms. As well, the majority of ODs have boundaries that are not aligned with any D/M boundary – one OD includes part of one SNA while another OD covers the rest of the SNA (See Figure 7). The reasons for this mismatch have a practical rationale. The MOH sets OD boundaries based on a rational catchment area for the OD referral hospital, based on the principle of maximizing access to the health facility. However, these boundaries need to be updated periodically in the light of changes in road transport infrastructure and population distribution.

Figure 8 summarizes the mapping of referral hospitals to D/Ms. Figure 9 summarizes the mapping of health centres to C/Ss. This data is drawn from the 2010 HCP database. This data base is accessible and can provide details of the locations of each health facility and its staff numbers in GIS mapping and spread sheet formats. As of 2010, 114 D/Ms did not have a referral hospital inside their territory – they access RH in a neighbouring district. Some 737 communes did not have an HC. Some of these communes in remote areas have a small health post offering a limited range of services, but most of these communes access an HC in a neighbouring commune/sangkat. The MOH has a program of construction of new HCs that aims to provide an HC in every commune that meets HCP criteria by 2014. Additionally, the MOH plans to create new ODs and construct additional RHs in some remote provinces that are currently single OD PHDs by 2015.

It will be important to ensure that updated Health Coverage Plan information and personnel data and projections of future personnel are incorporated into any planning and costing of functional transfers in the MOH closer to the date at which such transfers take place.

Figure 6: Map of Health Operational Districts showing Province and District/Municipal Boundaries

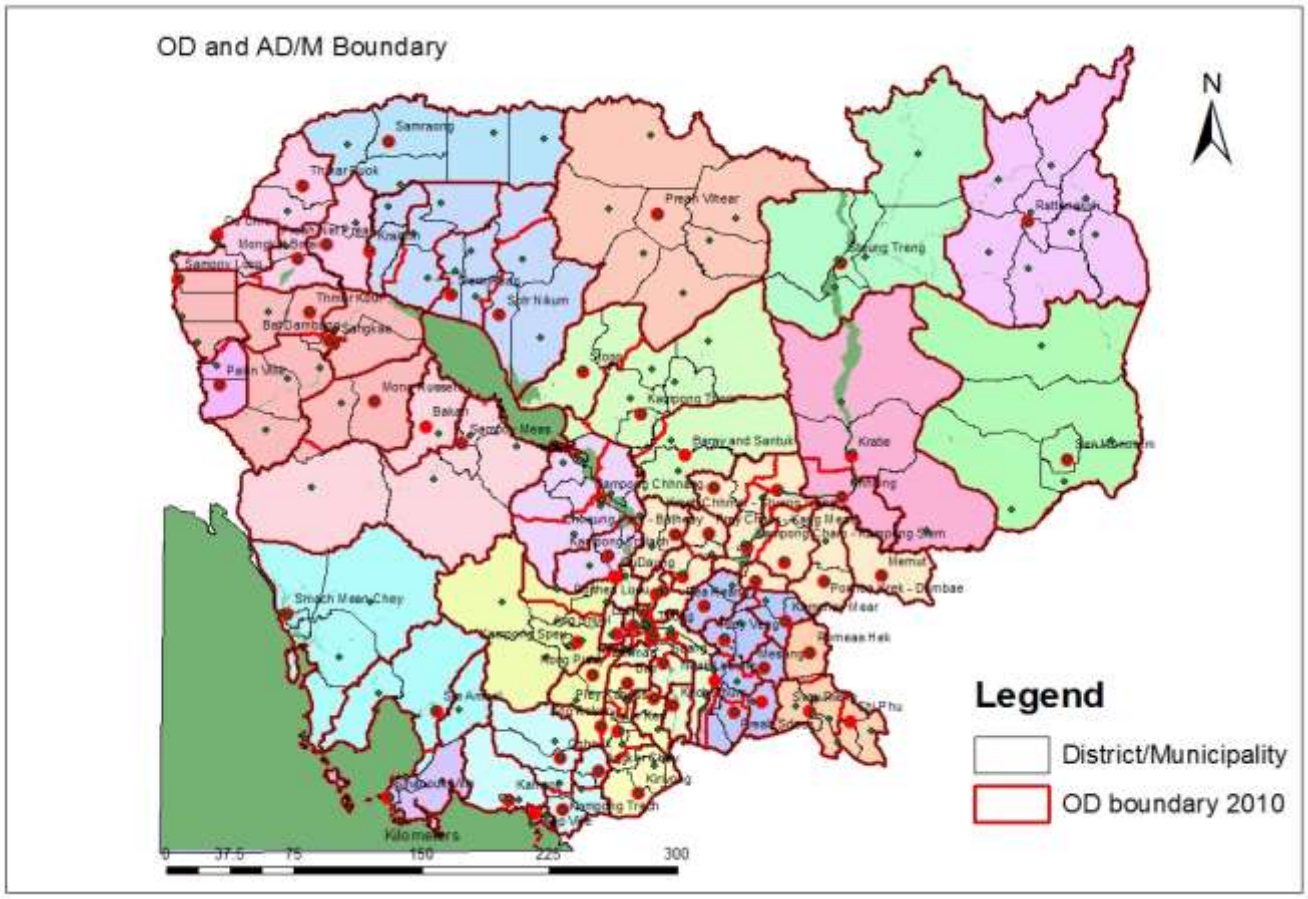


Figure 7: Mapping of MOH Operational Districts to District/Municipality and Provinces (2010 data)

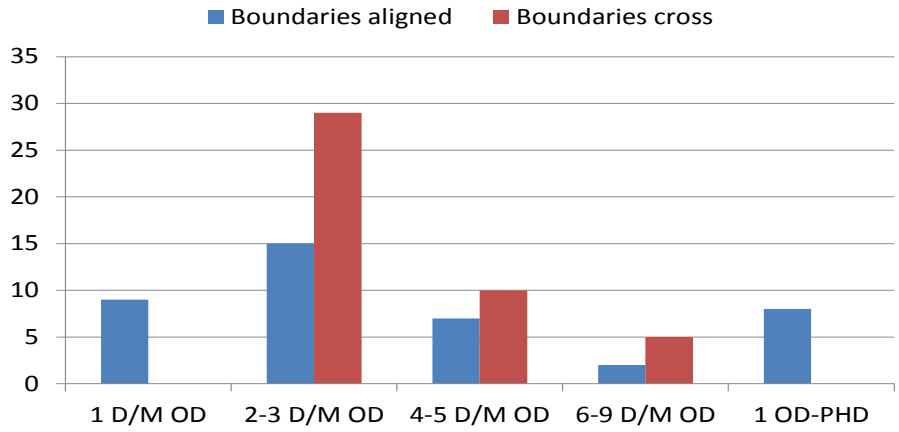


Figure 8: Number of Districts/Municipalities with & without referral hospital (2010)

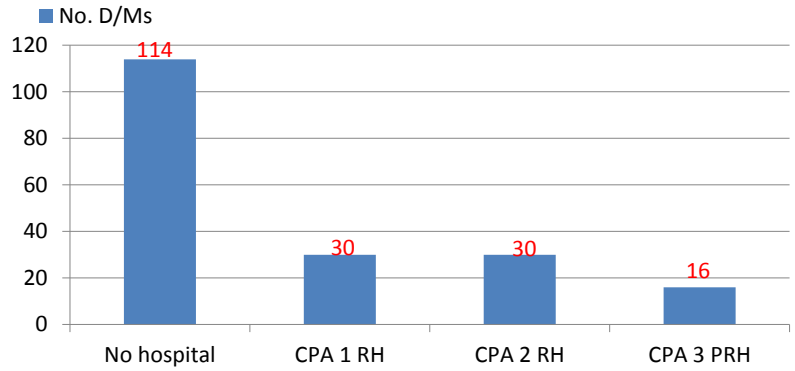
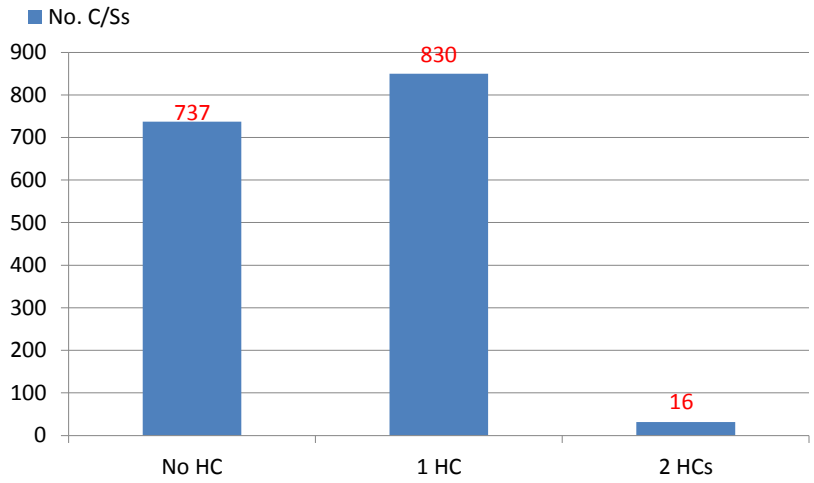


Figure 9: Number of Communes/Sangkats with or without health center (2010)



VII. Mapping of Financial Resources from Government and Donors

Table 7.1 summarizes aggregate MOH expenditure from the RGC budget by economic classification. Table 7.2 provides aggregate data on program budget expenditure. However, disaggregation of program expenditure by program is not available. The MOH's program budgets are:

- P1: Mother and Child Health (MCH)
- P2: Communicable Disease Control (CDC)
- P3: Non-communicable Disease Control (NCDC)
- P4: Health System Strengthening (HSS), including training and health financing

TABLE 7.1 Ministry of Health: Expenditure (Economic Classification)
Central Ministry level, Provinces, including district level 2009, 2010, 2011 (Million Riel)

Classification / Location / Year	2009		2010		2011	
	Actual Disbursed	Approved Budget Plan	Actual Disbursed	Approved Budget Plan	Actual Disbursed	Approved Budget Plan
A. Ministry Level (Program and Non Program Combined)						
Personnel Expenditures (Ch. 64)	22,475.59	23,011.00	24,118.92	26,208.00	23,983.60	27,628.00
Non-Wage Current Expenditures (Ch.60, 61, 62, 63, 65)	345,608.27	319,808.60	421,715.33	393,508.00	446,074.20	417,415.60
Capital Expenditures	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Sub Total	368,083.86	342,819.60	445,834.25	419,716.00	470,057.80	445,043.60
B. Provincial Departments of Ministry/Institution (all Provinces Combined and District Data)						
Personnel Expenditures (Ch. 64)	73,375.94	79,100.00	85,064.94	93,292.00	94,800.08	106,353.00
Non-Wage Current Expenditures (ch. 60,61, 62, 63, 65)	83,049.88	81,927.00	84,416.75	87,048.00	102,516.94	102,497.10
Capital Expenditures	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Sub Total	156,425.82	161,027.00	169,481.69	180,340.00	197,317.02	208,850.10
C. Total Ministries/Institutions (Central and Provincial Level)						
Personnel Expenditures (Ch. 64)	95,851.53	102,111.00	109,183.87	119,500.00	118,783.68	133,981.00
Non-Wage Current Expenditures (Ch. 60,61, 62, 63, 65)	428,658.15	401,735.60	506,132.07	480,556.00	548,591.14	519,912.70
Capital Expenditures	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Grand Total	524,509.68	503,846.60	615,315.94	600,056.00	667,374.82	653,893.70

Note that definitions of expenditure included in program budgets have been revised each year, so that year-to-year comparison is difficult to interpret. Program budgets do not include salaries and allowances or major capital expenditure.

Table 7.2: Ministry of Health: Expenditures by Program
2009, 2010, 2011 (Million Riel)

Program	2009		2010		2011	
	Approved Budget	Actual	Approved Budget	Actual	Approved Budget	Actual
Program 1: Maternal, Reproductive and Child Health						
Sub Total	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Program 2: Communicable Disease Control						
Sub Total	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Program 3: Non-Communicable Disease Control						
Sub Total	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Program 4: Health Systems Strengthening						
Sub Total	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Total Ministry: Programs 1+2+3+4			**11963.2**	**10982.1**	**13115.8**	**11936.8**

Table 7.3 attempts to map planned MOH expenditure from the RGC budget by major functional groups. It is not feasible to map MOH expenditure to detailed functions at the level listed in Table 5. Data in this table are drawn from the MOH's Annual Operational Plan (AOP) for 2012. Please note that the MOH's approved budget differs from the AOP. However, it is not possible to map MOH budget expenditure to functions. Nor is data available on actual expenditure according to the AOP classification.

Table 8.1 lists all of the MOH's development assistance, as recorded in the website of the Cambodian Development Council. The table includes all programs in the Health and HIV/AIDS sector programs in which MOH or a private or NGO health sector agency are beneficiaries and which disbursed in one or more of fiscal years 2010, 2011 and 2012 (to date).

Table 8.2 attempts to map planned MOH expenditure supported by DPs by major functional groups, for DP support that is included in the MOH's AOP for 2012. Please note that some donors do not submit data to the AOP process so the totals included in Table 8.2 are significantly lower than in Table 8.1.

Table 7.3: Expenditures of MOH by Functional Groups 2012 (billion Riel)
(Annual Operating Plan data for Government budget 2012: note AOP data differs from approved budget plan)

Functions (broad groups of functions)	Central Level						Capital/Provincial Level						Operational District Level						Grand Total
	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	
"Back office" functions, training & research	21.9	8.1	12.5	2.1	9.4	**54**	79.9	.24	.76	.13	8.4	**89.43**	35.2	2.2	.59	.20	9.4	**47.59**	**191.02**
Service delivery functions																			
Primary care	0	0	0	0	0	**0**	0	0	0	0	0	**0**	23.2	8.4	1.1	.40	8.3	**41.4**	**41.4**
Hospital care	28.5	9.4	.03	.01	.26	**38.2**	12.4	.78	.05	.90	23.4	**37.53**	12.4	1.4	.07	.07	4.8	**18.74**	**94.47**
Total	**50.4**	**17.5**	**12.53**	**2.11**	**9.66**	**92.2**	**92.3**	**1.02**	**.81**	**1.03**	**31.8**	**127.0**	**70.8**	**12**	**1.76**	**.67**	**22.5**	**107.7**	**326.89**

TABLE 8.1 List of Program and Sector Projects of Development Partners in MOH & health sector (US$) (1)

(Data Source: CDC website October 2012, all health or HIV/AIDS projects disbursing since 2010 except those implemented by sectoral line Ministries other than MOH)

No	Sector & Sub-Sector of Project	Donor	Total Budget (US dollars)	%	2010 Budget disbursed	2011 Budget disbursed	2012 Budget disbursed
	Health - Primary Health						
1	GR 0025-CAM GMS: Regional Communicable Diseases Control	ADB	10,980,000	0.83	640,000		
2	JF 9057 Health Care Financing for the Poor	ADB	2,467,000	0.19	500,000	300,000	
3	Avoidable Blindness Initiative	Australia	4,358,244	0.33	1,862,981	2,122,212	
4	Adventist Development and Relief Agency (ADRA) Program 2006 - 2011	Canada	885,956	0.07	289,063	44,693	
5	Community Based Health and Development Project	EU/EC	973,793	0.07	153,183		148,267
6	Improving health through better sanitation and hygiene in Kampong Chhnang province, Cambodia	EU/EC	581,448	0.04		263,031	
7	Improving the Situation for Disadvantaged Groups in Rural Cambodia: A Capacity Building Approach to Community Mental Health Care	EU/EC	1,374,935	0.10		130,454	
8	Reaching the health related Cambodia MDGs: promoting primary healthcare for rural communities in Preah Vihear province	EU/EC	663,102	0.05	177,680	220,677	162,264
9	Project of Community Based Health Care for Mothers and Children in Kampong Thom Province (Phase II)	Japan	121,828	0.01			121,828
10	The Project for Improving Maternal and Child Health Service in Rural Area	Japan	1,966,928	0.15	16,366		
11	The Project for Improving Maternal and Child Health Services in Kampong Thom Province	Japan	88,983	0.01	18,384		
12	Health Sector Support (HSSP) - Maternal Mortality Reduction (MMR)	UK	5,087,524	0.39	297,560		
13	Country Programme Action Plan 2006-2010, Child Survival Programme	UNICEF	21,780,000	1.65	5,203,914		
14	Country Programme Action Plan 2011-2015: Maternal, Newborn Child Health and Nutrition (MNCHN)	UNICEF	24,500,000	1.86		4,066,363	3,837,133
15	Development of Community-Based Drug Abuse Counselling, Treatment and Rehabilitation Services in Cambodia	UNODC	685,100	0.05	44,900		
16	Support for Mother-and-Child Health	WFP	12,814,929	0.97	1,925,837	1,560,208	
17	Improved water supply for flood affected rural households, schools and health services in 5 target provinces of Cambodia	EU/EC	623,342	0.05			482,670
	Health - Immunization & Communicable Disease Control						
18	GR 0231 GMS: Regional Communicable Disease Control 2	ADB	10,000,000	0.76		1,000,000	1,500,000
19	Pandemic Preparedness	Australia	2,917,046	0.22	546,946	623,053	617,920
20	Support to the Pasteur Institute of Cambodia	France	2,209,480	0.17	283,190	418,994	
21	Immunization Services Support (ISS)	GAVI	1,421,920	0.11		252,500	166,500
22	Containing Artemisinin-Resistant Plasmodium Falciparum Parasite and Moving towards Malaria Pre-Elimination Status in Cambodia (Round 9 Malaria)	Global Fund	56,137,912	4.26	24,366,538	21,300,000	22,759,564
23	Further Scale-up of Proven Malaria Control Interventions towards Pre- Elimination of Malaria in Cambodia	Global Fund	10,916,537	0.83	5,391,396		
24	Increased Access to and Improved Quality of TB Services at OD and Community levels, with linkages to TB/HIV	Global Fund	8,294,808	0.63	3,043,367	3,700,000	
25	Renewed Efforts to Achieve High Coverage of Prevent Malaria Interventions and Scaling up the Response to High Anti-Malarial Drug Resistance in Cambodia	Global Fund	22,908,144	1.74	5,319,415	3,300,000	4,511,064
26	Scaling-up the Quality of Services for Tuberculosis (TB) and TB/HIV Patients including those in Remote and Underserved Populations, in Collaboration with Nongovernmental Organizations (NGOs)	Global Fund	9,022,696	0.69	1,437,637	550,000	
27	Strengthening of the National Malaria Control Program by Broadening Partnerships and Taking to Scale Proven BCC Interventions and Ushering in a "People's Movement for Malaria Control"	Global Fund	9,857,891	0.75	296,488		
28	National Tuberculosis Control Project (Phase II)	Japan	8,898,258	0.68	306		
29	The Project for Improving the Capacity of the National TB Control Program through Implemention of the 2nd National Prevalence Survey	Japan	2,753,006	0.21	1,171,251	789,646	947,532
30	The Project for Infectious Disease Control	Japan	2,606,734	0.20	2,377,444		
31	Intestinal Parasite Control in the Central area of Cambodia-2010	Republic of Kor	95,800	0.01	95,800		

TABLE 8.1 List of Program and Sector Projects of Development Partners in MOH & health sector (US$) (2)

No	Sector & Sub-Sector of Project	Donor	Total Budget (US dollars)	%	2010 Budget disbursed	2011 Budget disbursed	2012 Budget disbursed
	Health - Sector Wide Management (SWiM) & Sector Policy						
32	Cambodia Delivering Better Health	Australia	43,755,697	3.32	13,209,663	21,056,191	23,397,528
33	Quality of services, Medical insurance and Governance	France	9,283,820	0.71	1,401,753	2,101,237	1,201,202
34	Health System Strengthening (HSS)	GAVI	8,465,508	0.64	1,464,000	1,228,000	1,121,000
35	Social Health Protection (TC)	Germany	4,259,947	0.32	1,916,844	1,664,385	
36	Strengthening Cambodia's Health System in the Fight against HIV/AIDS, TB and Malaria	Global Fund	11,737,602	0.89	5,562,558	4,250,000	4,424,958
37	Strengthening Cambodia's Health System in the Fight Against HIV/AIDs, Tuberculosis and Malaria	Global Fund	3,486,893	0.26	614,204	1,575,637	
38	Health Sector Support (HSSP)	UK	18,701,700	1.42	297,560		
39	Health Sector Support Programme II (HSSP II)	UK	54,173,107	4.11	12,365,966	12,841,091	12,598,425
40	Join country/WHO collaborative programme 2010-2011	WHO	24,339,700	1.85	10,039,846	13,820,154	
41	Joint country/WHO collaborative programme 2008-2009	WHO	32,976,000	2.50	1,532,500	1,532,500	
42	Health - IDA Grant H0150: Health Sector Support Project	World Bank	7,800,000	0.59	9,000		
43	Health - MDTF - TF093574 - Second Health Sector Support Program	World Bank	52,092,675	3.96	13,018,701		
44	Health- Main - IDA 3728 Health Sector Support Project	World Bank	20,200,000	1.53	1,984,700		
45	Health -Main - IDA 44700 Cambodia Second Health Sector Support Program	World Bank	30,000,000	2.28	8,712,284	6,000,000	6,000,000
	Health - Reproductive Health						
46	Addressing the Reproductive Health, HIV and Primary Health Care Needs of Cambodian Women and Influencing Related National Policies	EU/EC	1,131,007	0.09	314,210	316,719	
47	Boosting Locally Based Health Education and Reproductive Health Services in Kompong Chhanang Province, Cambodia	EU/EC	503,123	0.04	210,875		68,904
48	Improving access to and quality of SRH services in Kompong Speu province - Cambodia	EU/EC	2,001,305	0.15		559,965	436,457
49	Improving the enabling environment to provide community led family planning and reproductive health to poor and vulnerable communities across 9 provinces - CAMBODIA	EU/EC	837,708	0.06		49,684	
50	Rural Cambodian Youth Sexual Reproductive Health (RCYSRH)	EU/EC	1,969,496	0.15	123,312		
51	Reproductive Health II	Germany	9,283,820	0.71	622,064	133,256	98,702
52	Reproductive Health III	Germany	6,631,300	0.50	538,907	2,588,490	3,517,721
53	Social Health Protection Programme I (Vouchers for Reproductive Health Services) (SHPP I)	Germany	3,315,650	0.25	373,959	407,418	1,414,877
54	Social Health Protection Programme II (FC) (Vouchers for Reproductive Health Services II) (SHPP II)	Germany	7,957,560	0.60			2,567,394
55	Increasing Access to Integrated Sexual Health and HIV Services for MSM in Phnom Penh	Japan	170,042	0.01	170,042		
56	Project for Community Based Health Care for Mothers and Children in Kampong Thom Province (Phase I)	Japan	131,100	0.01		131,100	
57	The Project for Improving Maternal and Newborn Care Through Midwifery Capacity Development	Japan	3,941,734	0.30	589,417	886,830	947,532
58	"KHM4R11C" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	20,523	0.00		20,523	
59	"KHM4R22C" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	1,945,718	0.15		1,945,718	
60	"KHM4R33C" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	313,537	0.02		313,537	
61	"KHM4U202" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	714,083	0.05			714,083
62	"KHM4U301" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	1,497,849	0.11			1,497,849
63	"KHM4U305" UNFPA Support to the Reproductive and Maternal Health Priorities of the Ministry of Health's Annual Operational Plans Through The Health Sector Support Programme II (HSSP2)	UNFPA	25,000	0.00			25,000
64	Behaviour Change Communication for Improving Reproductive and Maternal Health	UNFPA	617,383	0.05	83,729		
65	CMB3R11C - UNFPA Support to the Reproductive & Maternal Health Priorities of the Ministry of Health's Annual Operational Plans through the Health Sector Support Programme II (HSSP II)	UNFPA	520,118	0.04	260,000	30,000	
66	CMB3R11J - UNFPA Support to Young People's Reproductive and Sexual Health	UNFPA	99,205	0.01	59,595		
67	CMB3R22C - UNFPA Support to the Reproductive & Maternal Health Priorities of the Ministry of Health's Annual Operational Plans through the Health Sector Support Programme II (HSSP II)	UNFPA	3,629,978	0.28	1,547,099	90,137	
68	CMB3R33C - UNFPA Support to the Reproductive & Maternal Health Priorities of the Ministry of Health's Annual Operational Plans through the Health Sector Support Programme II (HSSP II)	UNFPA	3,117,970	0.24	1,151,491	74,943	
69	CMB3R54C - UNFPA Support to the Reproductive & Maternal Health Priorities of the Ministry of Health's Annual Operational Plans through the Health Sector Support Programme II (HSSP II)	UNFPA	215,242	0.02	49,762	32,903	
70	CMBR354J - UNFPA Support to Young People's Reproductive and Sexual Health	UNFPA	441,984	0.03	135,198	14,354	

TABLE 8.1 List of Program and Sector Projects of Development Partners in MOH & health sector (US$) (3)

No	Sector & Sub-Sector of Project	Donor	Total Budget (US dollars)	%	2010 Budget disbursed	2011 Budget disbursed	2012 Budget disbursed
	Health - Medical Education						
71	Community Based Health Development Programme CBHD	Finland	228,411	0.02	228,411		
72	FSP "Supporting University of Health Sciences"	France	1,031,830	0.08	449,512	334,841	
73	Project for Improving Maternal and Child Health Services in Svay Anthor Operational District	Japan	323,270	0.02	323,270		
74	Project on Human Resource Development for Co-medicals	Japan	6,008,818	0.46	81,137		
75	The Project for Improving Maternal and Child Health (MCH) Services in Kampong Thom Province (Phase II)	Japan	91,908	0.01	51,302	40,606	
76	The Project for Strengthening Human Resources Development System of Co-Medicals	Japan	3,508,415	0.27	310,281	696,848	947,532
	Health - Medicines & Equipment						
77	New and Under-used Vaccines Support (NVS): Penta	GAVI	27,599,500	2.10	4,753,690	3,509,500	3,312,000
78	The Project for Installing Medical Equipment in Prey Kabas Referral Hospital in Takeo Province	Japan	87,314	0.01	87,314		
79	Intestinal Parasite Control in the central Area of Cambodia-2011	Republic of Korea	91,000	0.01		91,000	
	Health - Hospitals						
80	Project for Improvement of Kampong Cham Hospital in Kampong Cham Province	Japan	11,775,640	0.89	4,326,612	1,102,508	
81	Project for Improving Mother and Child Health in Kampong Thom Referral Hospital	Japan	27,494	0.00	27,494		
82	Project for Installing Medical Equipment for Operating Room in Cheung Prey Referral Hospital in Kampong Cham Province.	Japan	92,290	0.01			92,290
83	Project for Installing Medical Waste Incinerator at Angkor Hospital for Children in Siem Reap Province	Japan	55,325	0.00		55,325	
84	The Project for Constructing Emergency Ward and Installing Medical Equipment for Emergency Ward at Ratanakiri Referral Hospital	Japan	84,674	0.01		84,674	
85	The Project for Construction of General Medical Care Ward in Pea Raing Referral Hospital in Prey Veng Province	Japan	97,100	0.01			97,100
86	The Project for Extension of Delivery Rooms at Eight Health Centers in Takeo Province	Japan	74,333	0.01			74,333
87	The Project for Improvement of Medical Equipment in National, Municipal and Provincial Referral Hospitals	Japan	4,238,777	0.32			1,817,316
88	Establishing Rural health Center in Kong Pisey Cambodia-2011	Republic of Korea	132,000	0.01		132,000	
89	Project for the Establishment of Preah Angduong Eye Hospital in Phnom Penh, Cambodia	Republic of Korea	5,500,000	0.42		130,000	748,000
90	Project for the Strengthening Capacity of Batheay Referral Hospital in Batheay District, Kampong Cham Province	Republic of Korea	3,500,000	0.27		671,000	1,121,000
91	Contribution to programmes of Swiss NGOs active in Cambodia	Switzerland	5,811,069	0.44	276,718		
92	Kantha Bopha Hospitals	Switzerland	44,774,057	3.40	2,862,595	4,524,887	3,198,294
	Health - Other						
94	Provision of Basic Health Services in the Provinces of Siem Reap, Otdar Meanchey and Kampong Cham	Belgium	10,328,032	0.78	671,902	1,384,274	142,914
95	Community Based Health Insurance (CBHI) for the Rural Poor	EU/EC	726,527	0.06	220,159	231,844	
96	Health Behavioural Change Communication (BCC)	EU/EC	6,631,300	0.50	959,017	1,077,944	
97	Indigenous People Realising the Improvement of Good Health Through Sustainable Structures (IP RIGHTS) - Cambodia	EU/EC	915,345	0.07	218,568	230,168	
98	Prevention of road traffic injuries in Cambodia	EU/EC	977,479	0.07		41,953	
99	Promoting Access to Health Services for Marginalised Groups in Kohkong and Takeo Provinces of Cambodia	EU/EC	596,801	0.05	218,708	243,953	
100	Towards the local ownership of the rehabilitation sector for People with Physical Disabilities (PWPD)-CAMBODIA	EU/EC	1,980,849	0.15	162,328		
101	Hospital policy and micro-insurance	France	1,258,178	0.10	166,414		
102	Social Health Protection Programme II (TC)	Germany	5,636,605	0.43		1,047,486	2,246,470
103	Project for Strengthening Medical Equipment Management in Referral Hospital	Japan	4,616,459	0.35	871,851	1,227,079	947,532
104	The Project for Construction of Dormitory for Nurse and Midwife Trainees	Japan	98,343	0.01		98,343	
105	Public Health, sanitation education and alternative safe-drinking water source	Republic of Korea	27,049	0.00	27,049		
106	The Project of Strengthening of the Siem Reap Provincial Hospital Services in Cambodia	Republic of Korea	3,300,000	0.25	412,306	1,800,000	766,000

TABLE 8.1 List of Program and Sector Projects of Development Partners in MOH & health sector (US$) (4)

No	Sector & Sub-Sector of Project	Donor	Total Budget (US dollars)	%	2010 Budget disbursed	2011 Budget disbursed	2012 Budget disbursed
	HIV/AIDS						
107	Social Marketing for HIV and Reproductive Health	UK	11,587,751	0.88	1,990,912	2,889,246	583,493
108	Improved Health Services in HIV/AIDS and Infectious Diseases as well as in Maternal, Child and Reproductive Health	USA	368,126,799	27.96	36,417,785	33,342,100	38,504,640
109	HIV/AIDS Asia Regional Program	Australia	6,353,692	0.48	832,270	1,138,110	1,128,733
110	CARE Canada - Program 2007 - 2012	Canada	340,782	0.03	70,417	41,923	31,861
111	A project to develop, introduce and scale up a model for QVCT for HIV into clinics in Cambodia, Vietnam and Myanmar	EU/EC	3,089,997	0.23		93,936	
112	Increasing Community Action on HIV/AIDS Prevention integrated with Care and Impact Mitigation Efforts in Cambodia	EU/EC	3,475,594	0.26		744,145	702,311
113	ESTHER-ANRS Project	France	3,832,712	0.29	890,480		
114	Continued acheivement of Universal Access of HIV/Sexually Transmitted Infections Prevention, Treatment and Care services in Cambodia	Global Fund	53,402,333	4.06		32,000,000	27,968,832
115	Continuum of Care	Global Fund	36,546,134	2.78	2,747,636		
116	HIV/AIDs-Increasing Coverage in Key Service Areas	Global Fund	33,159,693	2.52	4,708,080	1,750,000	
117	Scalling up interventions for HIV Prevention, Treatment, Care and Mitigation for Vulnerable and Marginalized Populations and Risk	Global Fund	22,515,843	1.71	7,732,381		
118	Achieving Cambodia's Universal Access Targets for HIV Prevention, Treatment, Care and Support	UNAIDS	437,409	0.03			218,705
119	Strengthening HIV/AIDS activities in Cambodia	UNAIDS	430,000	0.03	186,873	159,939	
120	"KHM4R41D" UNFPA Support for Life Skills Education Program (LSEP) and Youth Development	UNFPA	19,560	0.00		19,560	
121	"KHM4U404" UNFPA SUPPORT LIFE SKILL EDUCATION PROGRAMME AND YOUTH DEVELOPMENT	UNFPA	57,000	0.00			57,000
122	Enhance National Capacity for HIV Prevention	UNFPA	38,250	0.00			38,250
123	Intensified Response to HIV/AIDS	UNFPA	266,285	0.02	67,046	74,072	
124	Country Programme Action Plan 2006-2010, HIV/AIDS Prevention and Care Programme	UNICEF	10,346,600	0.79	2,391,496		
	Total		**1,316,551,053**	100	**209,560,899**	**205,315,867**	**180,030,980**

CDC data - all health and HIV/AIDS projects disbursing in 2010, 2011 or 2012, excluding projects benefiting only non-MOH Ministries or non-health sector agencies

Table 8.2 Expenditures of MOH Development Partners by Functional Groups 2012 (billion Riel)
(Annual Operating Plan data for Development Partner expenditure 2012: note not all DPs plan spending through the AOPs)

Functions (broad groups of functions)	Central Level						Capital/Provincial Level						Operational District Level						Grand Total
	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	Non-prog.	P1 MCH	P2 CDC	P3 NCDC	P4 HSS	Total	
"Back office" functions, training & research (a)	169.9 (a)	19.8	226.9 (b)	4.1	16.7	**437.4**	.38	15.3	16.9	2.3	18.4	**53.3**	.98	13.6	8.6	2.1	24.0	**49.3**	**540.0**
Service delivery functions																			
Primary care	0	0	0	0	0	**0**	0	0	0	0	0	**0**	.33	.94	.89	.08	7.1	**9.3**	**9.3**
Hospital care	.32	0	0	0	0	**.32**	2.7	.22	1.3	.23	11.9	**16.4**	.73	10.3	4.4	.58	6.4	**22.4**	**39.1**
Total	**170.2**	**19.8**	**226.9**	**4.1**	**16.7**	**437.7**	**3.1**	**15.5**	**18.2**	**2.5**	**30.3**	**69.7**	**2.0**	**24.8**	**13.9**	**2.7**	**37.5**	**81.0**	**588.4**

VIII. MOH Experiences with De-concentration and Contracting In-Out

SOAs and Contracting In-Out

The MOH almost certainly has more experience with contracting out, internal contracting and de-concentration reform than any other sector in Cambodia. The MOH's 30 SOAs are a form of de-concentration that used internal performance-based management agreements. SOAs were introduced based on the RGC's 2006 Policy on Public Service Delivery.[1] SOAs are not separate legal entities. SOAs are designated organizational units of a Ministry with service delivery functions which are granted some additional delegations of managerial authority and flexibility by the parent Ministry, CAR and MEF and CAR under sub-decree and other policy issuances, in return for stronger accountability for performance. SOAs are, however, still fully subject to the civil service law and the law on budget. They are fully accountable to the MOH hierarchy, which retains responsibility for their performance. Strengthened accountability is embodied in a management contract between the Ministry hierarchy and the SOA director. CAR's guidelines for establishment of SOAs also emphasize improved performance management and accountability systems (PMAS) for staff, though CAR's aim is to extend such systems throughout all of the civil service staff, not just SOAs.

MOH SOA directors have been granted authority to change their internal organization and redeploy staff.[2] MEF has granted some additional budget flexibility to MOH SOAs to allocate their non-personnel recurrent costs budget. This is referred to as a Program Based Budget (PBB). These funds are allocated as a single line item (though reported using the new MEF chart of accounts) allowing the SOA to reallocate. PBB is advanced to MOH SOAs in fewer, larger tranches than the budget allocation for non-SOAs, and are paid into a commercial bank account operated by the SOA.[3]

All MOH SOAs have been established as part of a DP-financed initiative to pay donor-financed performance-related grants (SDGs) under an internal contract between MOH/PHD and the SOA. SOA status and SDG has been given to 22 Operational Districts (ODs) and 8 provincial referral hospitals (PRH). As a result, within the health sector, SDGs have tended to be seen as an integral part of being an SOA.

The SOA/SDG is package of reforms in health can best be understood by understanding its history. In the 1990's post-conflict context of fragmented direct NGO support to district health services, initiation of contracts between the MOH and NGOs gave the MOH a measure of control and introduced some NGO accountability. When the ADB first supported NGO performance contracting, it designed the project as a randomized pilot experiment that would test whether contracted NGOs performed better than public sector management of ODs. The evaluation showed the districts implementing NGO contracting, under two variants of contracting, improved key indicators more quickly than control districts.[4] Some health DPs relied on the positive findings of this evaluation of NGO contracting to advocate for scaling up. However, a careful reading of the evaluation points to the fact that NGO contracting districts achieved the improvement *with additional resources* compared to control districts; they also had freedom to pay staff higher salaries while control district staff could not, and faced far fewer procedural bottlenecks in accessing DP funding. The evaluation did not distinguish whether the improvement was mainly due to the additional resources or to the design of the NGO

[1] CAR (2006)

[2] Sub-decree No.69 ANKr.BK, 27 April, 2009

[3] PBB in 2010 were advanced directly from MOH to commercial bank accounts operated by the first 15 SOAs, but starting in 2011, PBBs for all SOAs were transferred by MEF to provincial treasury accounts. .

[4] Bloom, e. et al. (2006)

contracting intervention. As well, the evaluation treated the contracted NGO as a "black box" and did not attempt to determine whether the improvement in performance was mainly due to the higher salaries paid by NGOs to staff, reduced funding bottlenecks, the performance-related design of contract payments to the NGO, or the technical and management role of NGOs. MOH managers therefore argued that with similar freedoms to those enjoyed by the NGOs, they too could well have achieved similar results, without the added overhead cost of the international NGO.

Some later evaluations were critical of the fact that NGO contracting did not follow RGC regulations and systems of public financial management, characterizing it as a parallel donor project that bypassed government systems. These later reports also raised concerns about the sustainability of the NGO model and the limited progress in building local capacity.[5] The result of these unresolved issues and viewpoints was, firstly, a decision to carry out very limited scaling up of NGO contracting under HSSP to 10 districts by 2007, followed by an RGC decision in 2008 that all such NGO contracts would be terminated in early 2009. The design of SDGs was then carried out under a very tight timeframe as a replacement for NGO contracting with "internal contracting" – a performance contract between the MOH/PHD and the former contracted ODs. CAR's SOA policy provided a platform for development of management contracts within the MOH. The combination of DP needs (to replace NGO contracts) and the RGC service delivery policy agenda led to an HSSP2 design that piloted SOAs in a mix of ODs and provincial hospitals.

Available evidence on SOA/SDG and other contracting initiatives

SOAs/SDGs have not yet been evaluated. Studies of SOA/SDG have been commissioned by the World Bank and are expected to become available in late 2012 or early 2013. Rigorous evaluation of SOA/SDG is very difficult, given that: (i) SOA ODs have a distinctive history of higher levels of donor and technical support than most other ODs, making it difficult to compare their performance with other ODs; (ii) SOAs (like contracting NGOs) probably receive higher levels of funding on average and pay their staff higher total remuneration on average, so it would be difficult to attribute changes in performance to performance contracting design features; and (iii) there have been implementation issues with the performance component of the SDG and design problems with the grant allocation formula, leading to a series of revisions in design and implementation of design each year; so it would be difficult to attribute evaluation findings to design features, as distinct from implementation issues.

Available information on SOA/SDG performance comes from: reports from HSSP2 supervision, MOH analysis of HIS data, technical audit of HIS data and SDG implementation practices, and a study of NGO capacity building for SOAs. Simple comparison of SOA and non-SOA performance has been carried out using HIS data by the MOH for a small set of key HSP2 indicators. On average, SOA/SDG ODs have continued to improve performance on these indicators between 2008 and 2010. SOAs started with higher than average levels of utilization and performance on key HSP2 indicators (except for immunization) than non-SOAs, in part reflecting the long history of a relatively high level of donor/NGO support in most SOA ODs. Since then, SOAs made slower improvement on average than non-SOAs in some indicators (outpatient consultations and markedly slower performance in FBD). Following slower growth in SOA ANC 2 and DPT3-HEPB3 coverage than non-SOAs in 2009, SOAs reported a smaller decline in coverage rates than non-SOAs in 2010. At the end of 2010, the level of SOA OD performance indicators remained higher than non-SOAs on average. Variation in the pace of performance improvement is seen across SOAs. In particular, the minority of SOAs that exhibit flat or declining performance are more likely to be those with a shorter history (less than 3 years) or no prior history of NGO contracting/BTC support, though there are counterexamples of

[5] MOH (2008)

good performance among newer contracting/SOA ODs. However, no firm conclusions can be drawn from this simple comparison: we do not know, for example, if the slower pace of improvement in SOAs reflects their higher starting point: it may be more difficult and costly to achieve progressively higher rates of coverage. However, the continued performance improvement by SOAs suggests that the handover from NGO or DP management of donor funding to MOH OD management has been generally smooth. It has not led to performance set-backs, with a few exceptions.

On the other hand, given the substantial additional cost of SDGs, RGC and DPs will want to know if they are an efficient, cost-effective way of bringing about performance improvement. We lack data for assessing the cost effectiveness of SDGs. For example, there is no complete data reported to the central MOH on expenditure from all sources in each OD or facility in non-SOAs, so we cannot confirm whether or to what extent SOAs receive higher total RGC and donor resources compared to non-SOAs. Available data suggest SOA HC staff are paid higher salary supplements on average than GAVI-HSS ODs which also achieved a surge in performance on these core MCH indicators in the first 2 years of the program.[6] A study using 2006 data found that RHs with HEFs alone increased their bed occupancy rate at a faster rate and to similar levels compared to RHs in districts with NGO-contracting plus HEF.[7] However, there has not been any study comparing performance of SOA RHs with HEFs with non-SOA RHs with HEFs.

RGCs and DPs also want to assess whether the cost of SDGs is fiscally sustainable, if the RGC were to decide to SDGs should be scaled up. Simple calculation of the costs of scaling up SDGs to cover all of the country (excluding the Capital) at the current per capita grant allocation gives an estimated $15-16 million per annum cost. However, the question of fiscal sustainability also depends on the implications of SDG scale-up for salary relativities within the MOH and between SOA staff and the wider civil service. Scaling up SDG pay scales to all MOH permanent staff would cost of the order of $25-30 million a year.

Qualitative findings from SOA/SDG supervision, audit and reviews are generally positive about performance management by SOAs of their staff and teams. However, these reviews do not attempt to evaluate which of the variety of performance incentive schemes SOAs use is most appropriate or effective. Well-managed SOAs have implemented job descriptions, performance requirements and stronger discipline for all staff. Some SOAs are using these mechanisms as a basis for payment of not only the SDG incentives and also for salary top-ups from user fees and HEF revenues.[8] These practices, together with use of management contracts between the SOA director and RH and HC chiefs in some SOAs, are credited with playing a positive role in improving staff compliance with job requirements, staff morale and attitudes and opening hours of health facilities. Two evaluations of the GAVI HSS performance grants to HCs find similar improvement is attributed to this combination of job agreements and adequate incomes for staff. There has been no attempt to carry out studies comparing management changes under SOA/SDG compared to GAVI/HSS ODs and to control districts with neither intervention. However, the GAVI HSS evaluation noted that this more program did not achieve the objective of strengthening management in a comprehensive and integrated manner: management and supervision remained mostly vertical, within the NIP program, and this may have led to a lower focus on performance components (e.g. family planning) that were the responsibility of other programs.[9]

[6] Biacabe, S. (2009)
[7] Annear, P. et al. (2008)
[8] An HR survey supported by the World Bank has been carried out to validate these observations, find out how many SOAs and PAE hospitals are implementing good personnel management practices, and attempt some evaluation of the effectiveness of different incentive schemes.
[9] Biacabe, S. (2009) and Murakami, H. et al. (2009)

Financial management is generally stronger in SOA ODs than non-SOAs. SOA ODs do prepare accounts, whereas non-SOA ODs usually undertake little accounting. Although initial financial management assessment of SOA candidates for accreditation was disappointing and there is still variation in compliance with consolidated reporting of expenditure from all sources of finance, capacity building has since been provided by NGOs and by the MOH's Department of Budget and Finance.[10] Financial management assessments emphasize that the fragmentation of financing streams, rules and procedures MOH facilities face is one of the major challenges impeding improvement in key aspects of financial management, in both budget formulation and execution. This fragmentation is arguably greater than in other MOH facilities because of the additional rules applying to different components of the SDG.

HSSP2 supervision reports and technical audits note problems with initial design and implementation of the variable components of the SDG: the performance-linked 15% tranche of the SDG (initially based on performance targets negotiated locally between PHDs and SOAs), and a 5% component for local allocation by the PHD as "commissioner". Some of the problems are technical, and these are now being addressed. But the problems are also related to lack of progress in developing the PHDs' role in managing and monitoring the performance contracts. An assessment of institutional capacity building for this role found that capacity development was "underachieved" and in need of further support in three out of five PHDs.[11] The contract management role for SDGs is also carried out by the HSSP secretariat, supported by the central MOH's Service Delivery Monitoring Group. SOAs perceive overlap in monitoring and supervision and in their lines of accountability: to PHDs and HSSP2 secretariat/central MOH

The SOA/SDG technical audit finds that the quality of healthcare in SOAs is held back by a shortage of key skilled staff (especially secondary midwives), and by a shortage of funds for non-salary operating costs. The GAVI HSS evaluation cited above observed a range of factors inhibiting quality of care, including shortage of secondary level staff; weak clinical skills in a number of fields; problems with water supply, hygiene and equipment in some facilities. This evaluation recommended a shift in focus, after a first phase of emphasis on targets and outputs, to an emphasis on sustaining coverage and quality improvement.

IX. MOH Process of Validation, Consultation and Approval of Functional Mapping

The MOH validated and consulted on its functional mapping through the following processes:

1. Successive meetings of the MOH D&D working group from February 2011 – October 2012 which includes representatives of all central MOH departments and institutes, D&D focal points from each PHD and representatives of DPs;
2. Field work in five provinces and a sample of ODs in these provinces. These were selected purposively to cover different geographies: remote areas, typical rural areas, province towns and the Capital;
3. A round of five regional consultative workshops to which all PHDs, selected provincial councils and administrations, selected ODs and D/M councils and administrations were invited. One of the workshops also invited DP representatives, NCDD-S and MEDICAM (the umbrella organization for NGOs in health);
4. A national workshop in October 2012 to which all central MOH departments and institutes, all PHD Directors, NCDD-S, functional mapping technical assistance, MEDICAM and DPs were invited.

[10] MOH with HLSP (2010)
[11] Miller, P. (2011)

X. Conclusions: Key Issues Identified in Health Sector Mapping: Mismatch of ODs and D/Ms; Joint Functions & Linkages; SOAs; Pilots and Changing Functions

The functional mapping of the MOH found that including central functions in the mapping added considerably to the complexity of the task. At the next stage of functional review, it may be more practical to focus analysis on the functions that are present at province, district and community level. At these levels, the range of functions is shorter and simpler to describe and analyse.

Local Community Participation Functions in Health Are Mostly Unfunded Mandates

Local health functions in communes and villages are defined in the MOH's community health participation policy, but no government budget is allocated to them. These functions are supported by donors and NGOs in many but not all communes. In other places, these functions rely on the voluntary effort of village volunteers and limited support from health centre user fees income. A few communes are using UNDP or UNICEF grants for D&D for some of these functions.

The MOH's mandate for community participation in health area overlaps with the mandate of Ministry for Rural Development. The MOH policy describes ambitious functional responsibilities for commune/sangkat and village authorities, but it does not distinguish obligatory from permissive functions, nor does it assign clear responsibility for financing these community health functions. **These functions need to be costed and prioritized and C/S mandates and sources of funding clarified before the functions become formal mandates for C/S councils.**

Primary Care Functions: Health Centres Are Not Present in All Communes and Health Centre Functions Depend on Support from Operational District Offices

Primary care functions are carried out in health centres, health posts and by outreach. Not all communes have a health centre (infirmary) or health post. However, by 2015, the MOH plans to build a HC in every commune that has a population of 10,000 or more. Some HCs are in locations that attract patients from more than one commune.

Some key primary care functions are carried out by OD offices to support HC functions –the supply of vaccines, drugs and commodities, and ambulance transport for emergencies. Health centres also rely on OD staff for technical support and regular training. ODs monitor HC functions to ensure the whole population is covered with essential services including immunization, nutrition supplements, infectious disease control, antenatal and post-natal care.

For these reasons, **when health centres are transferred to SNAs, it would be difficult to transfer them to communes, and it will also be necessary to ensure continuity of support to their functions from Operational District level or higher levels of the health system.**

Mismatch of MOH's Operational Districts with SNA Districts and Municipalities

A major challenge for D&D identified in the functional mapping for the MOH arises from the mismatch between the MOH's 77 Health Operational Districts (OD) and the 185 D/Ms which are the basis for sub-national administration and democratic development. This mismatch means that there is not a simple way to transfer OD functions to D/Ms without major disruption to the management operations of health services.

MOH's ODs are organized around the catchment area of a referral hospital, which requires a minimum of 100,000 – 200,000 population. There are **technical reasons <u>not</u> to transfer referral hospital functions to every D/M**. Most districts have populations of 50,000-60,000 which is not

large enough to support a referral hospital. Having a hospital for such a small number of people would be inefficient. There is a global trend to have fewer, larger hospitals with larger catchment populations. However, in remote and sparsely population areas there will continue to be a need for a small hospital to provide safe access times for emergency cases even though the catchment population is lower than optimal for efficiency.

A further problem arises with transferring the functions of OD offices to D/Ms. OD offices have a team of technical staff that support and supervise HCs. They also carry out some delegated health functions at local level for the PHD and for national health programs. Typically they have 12-20 staff. Some of these staff are trained to play specialized roles in relation to particular vertical programs and pharmaceutical management. **Dividing OD office staff across 2-3 D/Ms would run the risk of giving D/Ms too small a health office to carry out the full range of functions** that OD office performs now. If the RGC decides to create a fully functional health office in every D/M, there will be a need to increase the staff quota and salaries budget and recruit and train additional technical staff over time. One alternative solution suggested by the Organic Law is that OD functions that benefit more than one AD should not be decentralized – they should be managed at a higher level – i.e. the province level. However, the Organic Law also provides for **joint transfer** of functions to more than one D/M (in Article 236). Some countries address inter-district service delivery issues by encouraging neighbouring SNAs to come together to create **joint service delivery organizations**.

There is Asymmetry in the Assignment of Functions to Different MOH ODs, Depending on Geographic and Population Characteristics

Different functional assignments are adopted in ODs where the province administration is located and in remote and sparsely populated provinces. In ODs where the province administration is located, the provincial health department is responsible for the referral hospital and the OD has no hospital functions. In remote and sparsely populated provinces, the PHD also takes on the functions of the OD. **Asymmetric assignment of health functions is likely to be necessary for municipalities where the province administration is located and in remote and sparsely populated provinces under D&D.**

Teamwork and Multi-Tasking

Functional mapping highlighted that well-functioning OD offices and health centres make extensive use of integrated team-work and multi-tasking, and it is MOH policy to encourage this type of integration. **Integrated team activities should be kept together to the fullest extent possible in any functional transfers.** There are few or no staff in OD offices or health centres who work on only one or two stand-alone functions that could be easily separated from other OD or HC functions and transferred to SNAs, with the limited exception of some non-medical functions that are often carried out by contractual staff (e.g. repairs and maintenance).

Joint Functions and Linkages between Different Levels of the Health System

The master-list mapping MOH functions (Table 5) illustrates the fact that many of the functions of the MOH are **joint functions** of central, province, OD and health facility levels. Many of these joint functions involve coordination and communication linkages between the central and sub-national levels of the health system. This is a typical feature of public health systems around the world for several major reasons related to **specialization and economies of scale,** and the need for **coordination of the referral and disease surveillance systems.**

Many MOH human resource and service delivery functions require highly specialized technical expertise that is only available at central level and/or in selected regional centres and/or in PHDs. Technical guidance on health care, technical training and technical supervision/support to lower

levels of administration and health facilities are therefore carried out by the central Ministry of Health, national centres and institutes, regional training centres and PHDs.

Specialized health services exhibit economies of scale because of the requirement for scarce specialist expertise and/or high cost specialized equipment and facilities. As a result, the health facilities network in Cambodia (as in other countries) is organized in different levels of care, connected by a referral system. Common, less complex conditions can be treated efficiently in primary care level facilities. Less common, more complex conditions must be referred for treatment to Referral Hospitals, of different levels: OD referral hospitals without surgical capability (CPA1), OD referral hospitals with surgical capability (CPA2) and Provincial Referral Hospitals with multiple specialist departments and diagnostic facilities (CPA3). The rarest and most complex conditions require referral to specialist national hospitals.

Some aspects of communicable disease prevention functions also exhibit economies of scale. Communicable disease surveillance and control of outbreaks requires effective communication and coordination between different levels of the health system, with specialized expertise and laboratory capacity located at national level, and sometimes requiring international coordination.

Finally, there are economies of scale in management of supply chains for pharmaceuticals, vaccines and some other health commodities. Economies of scale arise because bulk procurement can achieve lower prices, because international procurement is required for many pharmaceuticals and vaccines, and because specialized quality control is needed to ensure safety of these products.

SOAs

SOAs represent a form of **de-concentration** and have built capacity for management at OD level in the MOH. This can be useful preparation for implementation of D&D in health. Lessons from SOA experience and from the MOH's experience with PAEs could also be used to help design a decentralized joint service delivery organization, if the RGC chooses to pursue this option for decentralizing OD functions to groups of neighbouring D/Ms, as discussed above. However, the SOA sub-decree is not suitable for decentralization because it is based on the concept of internal contracting between the central MOH or PHD and the local SOA. The SOA is based on stronger vertical accountability for performance. **To decentralize SOAs, it would be necessary to develop a new legal instrument for a local semi-autonomous agency that is accountable to SNAs for performance.**

Pilots and Changing Functions

The functional mapping identified a number of MOH functions that are pilots, operating only in some parts of the country, and highly dependent on DP support. **It may be desirable for the MOH to evaluate these pilots and make a decision on whether to scale them up and how to adapt their design to D&D before functional transfers are made.**

The MOH has plans to develop some major **policy reforms in health finance** that have implications for D&D, and in particular for the design of fiscal aspects of decentralization. These policies are not yet finalized or formally adopted, so there is likely to be a **need to ensure coordination of health finance and D&D policy decision-making processes at key stages**. Finally, the MOH plans to review and update its Health Coverage Plan and expand the health network to keep pace with population growth. **Updates from these new plans will need to be obtained before any future decisions on personnel or facilities transfers.**

Annexes

Annex 1: Health Coverage Plan Staffing Standards

Minimum Package of Activities: Health Centre (HC) Staffing Standard

	Qualification	Type A HC	Type B HC	Type C HC	Type D HC
1	Doctor (MD)/Medical Assistant (MA)	0	0	1	1
2	Midwife – secondary level	1	2	2	2
3	Midwife – primary level	1	1	1	2
4	Nurse – secondary level	2	2	2	2
5	Nurse – primary level	2	2	2	2
6	Others	2	2	2	2
	Total	**8**	**9**	**10**	**11**

Complementary Package of Activities: Hospital Staffing Standard

	Qualification	CPA3 (Provincial Referral Hospital)	CPA2 (OD referral hospital with surgery)	CPA1 (OD referral hospital without surgery)
1	Doctor (MD)/Medical Assistant (MA)	9-21	7-10	5-7
2	Surgeon	6	3	0
3	Anesthesia	1	0	0
4	Pediatrician	1	0	0
5	Ophthalmologist	1	0	0
6	ENT doctor	1	0	0
7	Mental Health Doctor	1	0	0
8	Radiology specialist	2	1	0
9	Dentist	1	1	1
10	Dental Nurse	2	1	1
11	Nurse	59-89	13-23	15-22
12	Specialized Nurses	5	3	
13	Surgical Nurse	6	4	
14	Mental Health Nurse	3	2	

15	Midwife	15-20	7-10	6-8
16	Pharmacist	3-4	2-3	1-2
17	Lab technician	6-8	3-5	3
18	Radiology Technician/Operator	3	3	2
19	Physiotherapist	3-4	2-3	1-2
20	Maintenance staff	5-7	3-5	2-3
21	Cleaners	4-5	3-4	2-3
22	Laundry	3-4	2-3	1-2
23	Cook	3-4	2-3	1-2
24	Driver	1-2	1-2	1
25	Admin staff	4-6	3-4	2-5
26	Accounting	1-2	1	1
27	IT	1-2	1-2	1-2
28	Others			
	Total:	**155-212**	**68-96**	**47-65**

Annex 2: Projected MOH Staff Requirements at Health Facilities until 2020

	2010		2020		2011-2020			Annual
	Existing staff	Rate per 10,000 pop.	Total need	Rate per 10,000 pop.	Total gap	Attrition over 5 years	Total recruit-ment required	Recruit-ment required
Specialist MD	91	0.07	357	0.22	266	9	275	27
MD	2292	1.66	2697	1.67	405	458	864	86
MA	911	0.66	594	0.37	-317	182	0	0
Dentist	190	0.14	315	0.20	125	19	144	14
Dental Asst.	52	0.04	16	0.01	-36	5	0	0
Pharmacist	446	0.32	653	0.40	207	89	297	30
Pharmacist Asst.	102	0.07	108	0.07	6	10	16	2
2° nurse	5182	3.74	7508	4.65	2326	1036	3362	336
1° nurse	3311	2.39	5707	3.53	2396	1324	3721	372
2° midwife	1924	1.39	4482	2.78	2558	385	2942	294
Bachelor nurse	0	0	Not yet decided	Not yet decided				
Nurse specialist	0	0	Not yet decided	Not yet decided				
1°midwife	1834	1.33	2372	1.47	538	367	904	90
2° labtech	446	0.32	642	0.40	196	45	240	24
1° labtech	74	0.05	22	0.01	-52	7	0	0
Physio-therapist	125	0.09	256	0.16	131	13	143	14
X-ray	14	0.01	228	0.14	214	3	217	22
Admin	33	0.02	368	0.23	335	0	335	34
Accountant	103	0.07	223	0.14	120	0	120	12
IT	34	0.02	172	0.11	138	0	138	14
Maintenance	87	0.06	352	0.22	265	0	265	27
Drivers	52	0.04	156	0.10	104	0	104	10
Other	830	0.60	4680	2.90	3850	498	4348	435
TOTAL	**18133**	**13.10**	**31908**	**19.76**	**13775**	**4451**	**18436**	**1844**

Annex 3: Mapping of Provinces and ODs to SNA D/Ms, RHs, HCs, HPs and PHD office

Province	MOH Operational District	Population	No. SNA D/Ms	No. RHs	No. HCs	No. HPs	PHD
Banteay Meanchey	Mongkol Borei	239,378	2	1	22	4	PHD
Banteay Meanchey	Ou Chrov	197,361	3	1	13	3	
Banteay Meanchey	Preah Net Preah	146,556	2	1	15	5	
Banteay Meanchey	Thmar Puok	125,754	2	1	13	2	
Battambang	Thmar Koul	216,320	2	1	17	-	
Battambang	Mong Russei	197,991	3	1	13	-	
Battambang	Sampov Luon	144,369	3	1	10	-	
Battambang	Bat Dambang	354,403	6	-	23	2	PHD
Battambang	Sangkae	195,463	2	-	15	-	
Kampong Cham	Chamkar Leu - Stueng Trang	164,561	2	1	15	-	
Kampong Cham	Choeung Prey - Batheay	201,538	2	2	14	-	
Kampong Cham	Kampong Cham - Kampong Siem	306,502	5	1	23	-	PHD
Kampong Cham	Kroch Chhmar - Stueng Trang	114,881	2	1	11	-	
Kampong Cham	Memut	138,998	1	1	11	1	
Kampong Cham	O Reang Ov - Kaoh Soutin	103,492	2	1	9	-	
Kampong Cham	Ponhea Krek - Dambae	204,641	2	1	17	-	
Kampong Cham	Prey Chhor - Kang Meas	189,485	2	1	15	-	
Kampong Cham	Srei Santhor - Kang Meas	180,134	2	1	13	-	
Kampong Cham	Tbong Khmum - Kroch Chhmar	208,403	3	1	18	-	
Kampong Chhnang	Kampong Chhnang.	222,882	6	-	16	-	PHD
Kampong Chhnang	Kampong Tralach	169,286	3	1	12	-	
Kampong Chhnang	Boribo	114,293	4	1	11	-	
Kampong Speu	Kampong Speu.	394,715	7	-	22	-	PHD
Kampong Speu	Kong Pisey	260,277	3	1	19	-	
Kampong Speu	OuDaung	125,158	2	1	9	-	
Kampong Thom	Baray and Santuk	245,150	2	1	19	-	
Kampong Thom	Kampong Thom	285,227	7	-	21	-	PHD
Kampong Thom	Stong	140,481	2	1	10	-	
Kampot	Angkor Chey	119,541	2	1	11	-	
Kampot	Chhouk	181,621	3	2	17	-	
Kampot	Kampong Trach	167,239	3	1	12	-	
Kampot	Kampot	141,962	2	-	14	-	PHD
Kandal	Ang Snuol	76,969	1	-	8	-	
Kandal	Kean Svay	228,556	3	1	21	-	
Kandal	Kaoh Thum	168,000	1	1	12	-	
Kandal	Ksach Kandal	134,104	1	1	14	-	
Kandal	Mukh Kampul	72,483	1	1	6	-	
Kandal	Ponhea Lueu	90,305	1	-	9	1	
Kandal	Saang	173,755	1	1	13	1	
Kandal	Takhmau	214,635	4	-	13	-	PHD
Koh Kong	Smach Mean Chey	57,847	5	-	7	4	PHD

Province	MOH Operational District	Population	No. SNA D/Ms	No. RHs	No. HCs	No. HPs	PHD
Koh Kong	Sre Ambel	60,199	3	1	5	1	
Kratie	Chhlong	97,304	2	1	11	2	
Kratie	Kratie	233,896	5	1	20	9	PHD
Mondul Kiri	Sen Monorom	64,459	5	-	9	16	PHD
Phnom Penh	Cheung	319,688	3	1	9	1	
Phnom Penh	Kandal	227,372	2	1	4	-	PHD
Phnom Penh	Lech	454,182	4	1	11	5	
Phnom Penh	Tbong	321,238	2	1	9	1	
Preah Vihear	Preah Vihear	197,222	8	-	20	15	PHD
Prey Veng	Kamchay Mear	132,275	2	1	11	-	
Prey Veng	Kampong Trabek	143,419	2	1	11	-	
Prey Veng	Mesang	133,174	2	1	10	1	
Prey Veng	Neak Loeung	186,461	4	1	17	-	
Prey Veng	Pea Reang	201,750	2	1	16	3	
Prey Veng	Preah Sdach	119,204	2	1	9	-	
Prey Veng	Prey Veng	221,927	7	-	17	-	PHD
Pursat	Bakan	128,329	1	1	10	-	
Pursat	Sampov Meas	279,927	5	-	22	3	PHD
Ratanak Kiri	Rattanakiri	164,565	9	1	12	18	PHD
Siemreap	Kralanh	121,415	2	1	13	-	
Siemreap	Siem Reap	340,787	4	-	25	2	PHD
Siemreap	Sotr Nikum	265,482	3	1	23	1	
Siemreap	Angkor Chum	217,134	3	1	20	1	
Sihanoukville	Sihanouk Ville	192,940	4	-	13	1	PHD
Stung Treng	Steung Treng	123,025	5	-	12	-	PHD
Svay Rieng	Chi Phu	113,134	4	1	9	-	
Svay Rieng	Romeas Hek	139,079	2	1	9	-	
Svay Rieng	Svay Rieng	329,602	5	-	22	1	PHD
Takeo	Ang Rokar	141,079	1	1	10	1	
Takeo	Bati	201,603	2	1	13	-	
Takeo	Daun Keo	222,422	4	-	15	1	PHD
Takeo	Kirivong	232,514	4	1	22	2	
Takeo	Prey Kabass	169,506	3	1	14	1	
Oddar Meanchey	Samraong	219,192	5	1	23	3	PHD
Kep	Kep Ville	37,297	2	-	4	1	PHD
Pailin	Pailin Ville	68,748	2	-	6	-	PHD